BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

NINETY-THIRD CONGRESS

FIRST SESSION

PART 4—SPRINGFIELD, ILL.

MAY 16, 1973

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

98-780 WASHINGTON : 1973

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price 80 cents
Stock Number 5270-02082

SPECIAL COMMITTEE ON AGING

FRANK CHURCH, Idaho, *Chairman*

HARRISON A. WILLIAMS, JR., New Jersey
ALAN BIBLE, Nevada
JENNINGS RANDOLPH, West Virginia
EDMUND S. MUSKIE, Maine
FRANK E. MOSS, Utah
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
JOHN V. TUNNEY, California
LAWTON CHILES, Florida

HIRAM L. FONG, Hawaii
CLIFFORD P. HANSEN, Wyoming
EDWARD J. GURNEY, Florida
WILLIAM B. SAXBE, Ohio
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois
ROBERT T. STAFFORD, Vermont
J. GLENN BEALL, JR., Maryland
PETE V. DOMENICI, New Mexico

WILLIAM E. ORIOL, *Staff Director*
DAVID A. AFFELDT, *Chief Counsel*
VAL J. HALAMANDARIS, *Associate Counsel*
JOHN GUY MILLER, *Minority Staff Director*
PATRICIA G. ORIOL, *Chief Clerk*

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

EDMUND S. MUSKIE, *Chairman*

FRANK E. MOSS, Utah
HARRISON A. WILLIAMS, JR., New Jersey
EDWARD M. KENNEDY, Massachusetts
WALTER F. MONDALE, Minnesota
VANCE HARTKE, Indiana
CLAIBORNE PELL, Rhode Island
THOMAS F. EAGLETON, Missouri
JOHN V. TUNNEY, California
LAWTON CHILES, Florida

WILLIAM B. SAXBE, Ohio
HIRAM L. FONG, Hawaii
CLIFFORD P. HANSEN, Wyoming
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois
ROBERT T. STAFFORD, Vermont
PETE V. DOMENICI, New Mexico

Barriers to Health Care for Older Americans:
Part 1. Washington, D.C., March 5, 1973.
Part 2. Washington, D.C., March 6, 1973.
Part 3. Livermore Falls, Maine, April 23, 1973.
Part 4. Springfield, Ill., May 16, 1973.
Part 5. Washington, D.C., July 11, 1973.
Part 6. Washington, D.C., July 12, 1973.
Part 7. Coeur d'Alene, Idaho, August 4, 1973.
(Additional hearings anticipated but not scheduled at time of this printing.)

CONTENTS

CHRONOLOGICAL LIST OF WITNESSES

APPENDIXES

BARRIERS TO HEALTH CARE FOR OLDER AMERICANS

WEDNESDAY, MAY 16, 1973

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY OF THE
SPECIAL COMMITTEE ON AGING,
Springfield, Ill.

The subcommittee met, pursuant to notice, at 9 a.m., in the Illinois Theatre Building, State Fairgrounds, Springfield, Ill., Hon. Charles H. Percy, presiding.

Present: Senator Percy.

Also present: David Affeldt, chief counsel; Deborah K. Kilmer, professional staff member; John Guy Miller, minority staff director; Patricia G. Oriol, chief clerk; and Yvonne McCoy, clerk.

OPENING STATEMENT BY SENATOR CHARLES H. PERCY, PRESIDING

Senator PERCY. These hearings of the Subcommittee on Health of the Elderly of the U.S. Senate Special Committee on Aging will please come to order.

I am very pleased indeed to be able to welcome you. Is there anyone in the room that cannot hear?

If at any time you cannot hear the proceedings, will you please raise your hand, and we will ask the witnesses to speak up.

As many of you know, the Governor has tried to make his government an open government, and he has gone to the people. And, for the past 6½ years, I have tried to hold listen-ins around the State, some 50 or 60 of them, so it is not necessary to come to Washington to see your Government.

I have had the honor of holding hearings of U.S. Senate committees in Covington and in Chicago, but we have not had a meeting of this particular committee in Illinois, and it is quite appropriate we have it in Springfield, the State capital.

For those of you who would like to make your views known, and who would like to submit a statement in writing, a form has been provided at the back of the room for any of you in the audience to make your views known to the committee.

[See appendix 2, page 351].

You can either do it today and leave it with a staff member before he leaves, or if you want to make a written statement, it can be sent to the committee.

The address is right on the top of the form, and if it is sent to me before June 2, it will be made a part of the record of these hearings, and the hearing record will be left open until that time. It is the

yellow form addressed directly to me, and there is adequate room on it for you to make whatever comments you would like to make.

Prior to the comments by the Governor of the State of Illinois, with his indulgence, I have a short statement to open the proceedings officially.

I am extremely pleased that the Subcommittee on Health of the Elderly of the Senate Special Committee on Aging responded affirmatively to my suggestion that we continue our hearings on "Barriers to Health Care for Older Americans" here in Springfield today.

I regret, however, that the distinguished chairman of our subcommittee, Senator Muskie, is unable to be with us and to be a part of this most impressive gathering of the senior citizens of Illinois.

I am grateful that so many of you are participating in these and all the other activities which mark Senior Citizens Month.

We have much of which we can be proud this month. The Congress has passed and the President has signed the Older Americans Comprehensive Services Amendments of 1973. We can now build on and improve our basic structure of service programs for the elderly.

In addition, I believe that we will soon have funding—finally—for the nutrition program for the elderly.

I firmly believe—and I have fought for this program for years—that adequate nutrition is our very best form of preventive medicine.

I can say categorically, it simply would not have been possible for us to pass Social Security improvements I have sponsored without the help of senior citizens.

We in the Congress are limited to an extent about the people's sense of priorities for the country, and senior citizens themselves, through the use of senior power, not marching on Washington, or protesting in any violent manner, but by sheer reason and using the deliberative processes of our Government, have caused the Federal Government to provide the greatest increase of Social Security payments ever—20 percent in 1 year. At the same time you have caused the Government to incorporate the cost of living steady escalator in Social Security, so you do not have to wait for Congress to act when the cost of living goes up; to equalize once and for all benefits for men and women, and to take women out of the category where they received 82 percent, and put them in a 100-percent category.

I have never known any one woman who could live cheaper than a man.

Nutrition Program Funding

In addition, we will fund generously the nutrition program for the elderly. This started as a program I fought for several years ago with funding of $1.7 million to try to prove the principle that this country with all of its abundance could feed millions of people abroad, that we could find a way to use this abundance to feed and help in the nutrition process of our aging citizens, who, simply because of other costs, were taking money for medicine and other things out of their food budget. We have funded now, up to $250 million over 2 years, an experimental program that proved over several years its great value to our country, and to the elderly in the country.

I firmly believe—and many colleagues have fought right along with me for this program—that adequate nutrition is our best form of pre-

ventive medicine. Not only is the body strengthened by sitting down to a hot, nourishing meal with several of one's friends, but the spirit is strengthened as well. And this may be even more important.

We are also on our way to improving long-term care facilities for the aged, a problem to which I have personally devoted a great deal of time.

Many of you have been helpful in studying conditions right here in Springfield where we have had some tragedies.

Last year's Social Security amendments contained a number of nursing home provisions which I had sponsored or cosponsored, and they are now being implemented by HEW.

We shall not be discussing this subject today, but I can announce to you that Senator Moss' Subcommittee on Long-Term Care is completing and will shortly issue a comprehensive report which will deal at length with nursing home issues.

While we can be proud of what senior power has achieved, we all know there is a lot that remains to be done.

This subcommittee, for example, is concerned about the health care crisis facing the elderly, and I know of few problems which are of greater importance to older Americans and to their families and friends.

We want to learn what you perceive to be the most significant barriers to better health care, better nursing home care, and better preventive medicine for senior citizens.

But let me first reassure you, as clearly and as emphatically as I can, that Congress is not about to cripple Medicare.

I joined with more than 50 of my colleagues— a majority of the U.S. Senate—in cosponsoring a resolution introduced by Senator Mondale of Minnesota, which expresses our disapproval of the Medicare changes proposed in the fiscal year 1974 budget. These changes are not going to take place, and that is that.

It is said we can save a billion dollars by making these changes, but we are not going to take a billion dollars out of the hide of low-income elderly, who simply cannot afford that kind of cost.

We want to improve the access of the elderly to adequate health care services; we do not want to impair this access. We must find answers to spiraling costs for doctors, hospitals, extended care facilities, and, of course, drugs and medicine.

We must find ways of providing adequate transportation services so that the elderly can get to the doctor when it is necessary.

And we must provide home health services to those who may be infirm but not in need of hospitalization.

Members of this subcommittee do not have all the answers nor do we necessarily know all the barriers to health care which the elderly face in day-to-day life. That is why we are here—to listen and learn from you.

We depend very much on the assistance that you will give to this committee, and you will see what goes on every day in Washington—committees constantly seeking better answers to the problems we have, and trying to find the answers from the people that know better the nature of the problems that we know we have.

This is not just a Federal problem, but indeed an interrelationship of Federal, State, and local governments.

Senator Stevenson cannot be with us today due to other hearings being held in Washington, D.C.

The Senator's prepared statement will be incorporated in the transcript of this hearing.

STATEMENT BY SENATOR ADLAI STEVENSON III

Mr. Chairman, although I am unable to be with you today, I welcome you to Illinois for your hearings on a topic of major concern and importance: Barriers to health care for older Americans. I commend your efforts to investigate the proposed changes in the Medicare program which would affect 23 million elderly and disabled Americans.

I too am concerned about the effects of the President's proposal for Medicare funding. Medicare presently allows the elderly and the disabled—frequently individuals with fixed incomes and limited budgets—to receive treatment for illnesses without fear of a severe financial burden.

The President's proposal, however, would require Medicare recipients to pay 10 percent of all hospital costs beginning on the 2d rather than the 61st day of a hospital stay. Statistics show that almost 99 percent of all Medicare recipients are discharged from the hospital before the 61st day; such a change would benefit only 1 percent of the recipients. Any such change must be carefully scrutinized to avoid disastrous economic effects for the vast majority of the Nation's elderly.

In addition, I most emphatically do not agree with the President's implication that Medicare recipients want to be hospitalized and should be deterred from entering a hospital by higher costs.

In short, Mr. Chairman, I am opposed to this or any other proposal which would increase treatment costs for Medicare recipients. The proposed increase constitutes a major barrier to adequate health care for the elderly. I have, therefore, joined as a cosponsor of S. Con. Res. 18, which rejects the President's proposed Medicare program changes. A bipartisan majority in the Senate has joined in supporting this resolution, a true index of the Senate's concern over the insensitivity of this proposal.

Medicare was enacted less than a decade ago, its stated purpose being to protect the elderly and the disabled against the high costs of serious illness. I know that in these hearings you and your committee will keep this purpose foremost in your thoughts.

Senator PERCY. Our lead off witness is Gov. Daniel Walker.

Governor Walker, I welcome you as you have welcomed everybody here to Springfield.

STATEMENT OF HON. DANIEL WALKER, GOVERNOR OF THE STATE OF ILLINOIS

Governor WALKER. Thank you very much, Senator Percy.

I would like to start out by congratulating you for holding these hearings with the subcommittee.

You are permitting the people who are directly affected to present their viewpoints, and as you indicated earlier, I think that is an essential part of government.

I would also like to compliment you, Senator, for your long personal record of concern about our senior citizens.

That has been demonstrated before you went to the Senate, and it has been demonstrated repeatedly since you have been in the Senate, and without—well, you know—we have two U.S. Senators, ladies and gentlemen, and I think we ought to be very proud of both of them, and particularly proud for Senator Percy for coming out here to hear you.

[Applause.]

Better health care for elderly Americans is vital, as you know, and, Senator, over 10 percent of the men and women in the United States are over the age of 65, and Illinois mirrors that figure.

Over 1 million of the 11 million citizens in the State of Illinois are over 65.

I would like to stress, and I learned this firsthand, as I have spent a lot of time with people around the State in the last 2 years, that is, it is a mistake to lump together all of the senior citizens.

Some of them have severe problems. Others are at the very height of their powers. Some of them are almost literally isolated in communities of young people, intransient people, and others live in counties, and I have been in some of those counties around the State where almost a quarter of the population is over 65, but whether it is a man in southern Illinois, who used to be a coal miner, or a woman in a nursing home, they are all going to have health problems, all of us are, and many of the older Americans are really desperate in dealing with these problems.

I do want to say, Senator, I am disappointed with some of the recent trends that we observed in Washington, and, as you know, I am not speaking with respect to the Senate, the Congress, and in my brief remarks, I would like to outline just a few areas of specific concern.

Joel Edelman, the director of the Illinois State Department of Public Aid, will testify about these matters in detail.

One of these areas is the standards for nursing homes proposed in Public Law 92–203. I would agree totally that we have to upgrade the nursing homes in Illinois, but I suggest that some of the requirements of this law are unrealistic.

We estimate that these requirements would cause many nursing homes in the State of Illinois to literally go out of business, and would result in the loss of over 20,000 beds for patients in those nursing homes.

Medicaid and Medicare Administrative Problems

As you know, I am sure there are enormous problems, that the administration of Medicare and Medicaid have.

Medicare officials want more use of home health agency services, but the policy decisions of those officials in Washington have literally bankrupted many of those agencies with the denials of benefits, and retroactive payment denials to home health agencies is I think inexcusable.

There are many complaints revolving around inadequate coverage, for transportation to doctors, or to hospitals by Medicare, and there

is also an unfortunate lack of correlation between Medicare and Medicaid programs.

The federalization of the aged and disabled categories directed by Public Law 92–203 presents another kind of problem that Director Edelman will address himself to.

This is left to those who need both Medicare and Medicaid coverage confused about where they qualify, and this kind of confusion in the minds of people all over the State is something that I hope you can help us clear up.

I am also very distressed by what appears to be plans by the administration in Washington to reduce medical services to the senior citizen.

I suggest that this is no time to be reducing services.

This is a time for expanding services, yet the human resources section of the President's state of the Union speech recommends the elimination of Federal matching funds for adult dental care under Medicaid, and also a plan which would increase hospital costs for Medicare recipients.

National Health Insurance

More than any other step, we need, I believe, a uniform system of national health insurance.

There are a number of acceptable plans, the important thing is that this concept be incorporated into law.

Most people think of health insurance as a program not for our senior citizens, but it is those over 65 who need health insurance the most.

Finally, I have sought in Illinois, Senator, to put together a health team to deal with problems that cut across age, class, and regional differences.

Dr. Joyce Lashof, the first woman to be named director of the Department of Public Health in Illinois; Dr. Leroy Levitt, director of the Department of Mental Health; Dr. Mark Leper, who directs the Comprehensive Health Planning Agency, three outstanding doctors. In my fiscal 1974 budget message, I said, and I quote, the State's objective is a plan of comprehensive health service delivery, a system in which all members of the health partnership, State agencies, local governments, and the private sector play balanced or complementary roles, and you are absolutely right when you referred earlier to the ever growing role of the Federal Government, and the need for us at the State level to work closely with the Federal Government, and for the Federal Government to keep in mind that we have programs at the State level too.

Doctors Lashof, Levitt, and Leper will work as a team with Joel Edelman, director of the Department of Public Aid, for better health care and with health care for senior citizens of primary concern.

Again, Senator, I congratulate you and commend you for your interest and your work, and I would also like to commend everybody who took the time to be here today to play a personal role in the democratic process.

Thank you very much, Senator.

[Applause.]

Senator PERCY. I just would like to say that all those nice things the Governor had to say about me will have absolutely no effect on me when I face him next on the tennis court.

[Applause.]

Senator PERCY. Our next witnesses are the Honorable Neil F. Hartigan, Lieutenant Governor, State of Illinois, cosponsor of the senior citizens rally; and Mrs. Margaret L. Summers, executive director, White Cottage Senior Citizens, Sangamon County, cosponsor of the senior citizens rally.

Lieutenant Governor Hartigan, we are pleased to have your participation today, as well as Mrs. Margaret L. Summers.

STATEMENT OF HON. NEIL F. HARTIGAN, LIEUTENANT GOVERNOR, STATE OF ILLINOIS

Lieutenant Governor HARTIGAN. Thank you very much, Senator Percy.

Ladies and gentlemen, I would like to join Governor Walker, Senator Percy, in congratulating you, on not only this activity in coming here to Springfield today, and in the catalytic effect it has on increased interest in the very urgent needs of the senior community, but in your continuing support of the entire time you have been in the Senate, for the kind of legislation which increases the capacity of Government to deal with the very difficult problems that seniors who built this society are confronted with from a health and income point of view.

I think it is particularly appropriate at the hearing held today in Springfield, because tomorrow both the Illinois House and Senate will consider legislation that will establish a cabinet-level department on aging here in Illinois.

The report on which this legislation was based, "A Matter of Dignity," [1] is being provided for you.

Your hearing today, and the committee hearings tomorrow will bring greater attention and public recognition to the problems of our elderly. And, as a result, more importantly, bring solutions.

Today you are especially interested in barriers to health care. Certainly, no other area of concern is more important to senior citizens than that of health. And it is not just unfortunate, but disgraceful, that barriers do exist.

MAJOR OBSTACLES TO HEALTH CARE DELIVERY

Let me briefly outline what I consider to be major obstacles to effective delivery of health care to our elderly.

(1) Cost.—Despite Medicare and Medicaid, I might add I certainly concur with you in your disapproval in the Medicare changes, as far as the prospects are concerned, initial costs for medical care often result in senior citizens postponing medical care until an emergency.

This attitude directly opposes the concept of preventative treatment, and arresting health problems in early stages. It should be Govern-

[1] Retained in committee files.

ment policy to encourage early treatment by not creating economic barriers.

(2) Accessibility.—The elderly often live in areas not adequately served by health care personnel, and since their mobility tends in some instances to be limited, difficulty of access becomes in itself a major problem.

Obviously, we need specialized transportation facilities which connect medical care facilities and personnel with those seniors who need this care.

Whether that be the individualized with the special equipment on it for the person who is substantially disabled, or the kind of mass transportation facilities that make health care facilities a reality for the person otherwise isolated, in any of those areas, increased emphasis on proper modes of public transportation for the individual are very necessary.

(3) Low priority.—There have been only a few decades when the numbers and percentages of senior citizens have made the study of gerontology mandatory.

Gerontological or geriatric medicine is still neglected in most curricula. The particular illnesses of the elderly are not well understood. Many older people have health problems which are chronic, seemingly irreversible, or terminal.

These offer fewer opportunities for successful treatment and no one, not even doctors, choose to undertake projects, or accept patients that tend to fall in these categories.

As natural and inevitable as death is, unlike birth, it is not understood, and certainly not accepted. This too makes adequate treatment of the elderly patient more difficult. A basic solution to this problem would appear to encourage the private sector, and to make specific provisions in the public sector, for more courses in geriatric medicine, for scholarships and fellowships in this field, for special institutes for practicing physicians, nurses, and technicians, and other incentives to train health care personnel in this specialized field of medicine.

(4) Attitude toward the elderly.—Unfortunately some medical professionals fail to show sufficient empathy toward older people with medical problems.

One often repeated story is the case of an elderly gentleman describing an ache in his right leg. The doctor's response was: "What can you expect? That leg is over 80 years old."

To which the patient replied, "But so is the left one, and it doesn't hurt."

We must generate through our society, not just with health care personnel, although they are among those most intimately and importantly involved, a deep sense of concern and reverence for elderly citizens and a desire to make their years as senior citizens as healthy and productive as possible.

(5) Fear.—A major problem for senior citizens regarding health care is the fear of going to a doctor.

Fear of pain. Fear of institutionalization, especially in institutions where the human element is missing as it is far too often, and far too tragically. Some of the institutions are allegedly providing long-term nursing care, and I think all of us are aware, in fact in some in-

stances become dumping grounds and are a little more than dumping facilities.

Also, fear of hearing a bad diagnosis. And ultimately, the fear of death itself.

We must serve senior citizens in such a way that regular checkups are considered normal, useful, and necessary.

Crisis oriented treatment obviously induces fear. Regular checkups for all senior citizens, as a matter of course, would do a great deal to remove this present major obstacle.

(6) Lack of physicians.—Related to the problem of accessibility and shortage of specialized gerontological health personnel is the most acute shortage of general practitioners in rural areas, and within our inner cities.

I have suggested that we give full scholarships in medical schools in exchange for an agreement by the recipients that they will accept an assignment for a certain number of years in such areas.

Hopefully, the response from the community would be such that they would ultimately decide to make this a permanent location.

There are many other problems for senior citizens. Improper placement of older citizens in mental health facilities, or the subsequent dumping of such improperly placed patients into unsupervised dismal warehouses for the elderly is one terrible example.

The community setting is a vital factor in promoting good health.

The more active senior citizens are the greater they thrive. If you look at our major conductors, musicians, artists, and scientists, men and women who have been active and creative, we see tremendous longevity and health.

Toscanini, Rubinstein, Ormandy, Stokowski, Casals, Picasso, Chagall, Einstein, Fuller, Russell—all lived or are living full creative lives in their 80's and 90's.

Indeed, Senator Percy, your mother's activities as an accomplished violinist concertizing frequently is another good example that age need not be a barrier to a healthy, full, and rewarding life.

Once again, let me express my appreciation for this opportunity. I hope my testimony has been a little helpful, as well as our report. I stand ready to work with you, Senator, in this critical field.

State Cabinet-Level Department on Aging

And I pledge to you that we in Illinois will have within a few short months a State cabinet-level department on aging that will have the visibility to make greater accomplishments through effective advocacy.

No longer can we attach a welfare stigma to the millions of American citizens who through their work and taxes built this Nation and its States.

No longer can we hide the agencies which serve them so ineffectively in a bureaucratic maze. The answer and solutions will not come overnight. But they will come faster when we treat this area as we should, as a matter of dignity.

Thank you again.

Let me add, Mr. Chairman, what we are trying to do in Illinois. We are trying to take the question of the services for the aged off

of the low priority pool of the government. We are trying to raise the level of visibility as you are doing here by your hearings today, to make it a high priority of government, by bringing together a department, cabinet-level appointment by the Governor, where the seniors, for the first time in this country, would have both a director and a majority of the council that would provide the decisions on what programs should be funded; or should not be funded, because we feel very strongly that those who for 40 years through their work and paying of taxes have built this State, have built our government, are entitled to a decent return on their investment.

That is clearly true in the health area. I have been working closely with the Department of Health, Education, and Welfare, to interface the State with the Federal programs.

They feel as I do, the programs in the separate—in the offices of the State of Illinois result in confusion.

The individual seniors in this audience, or any other audience in this State, who are looking for an answer, may not get to that answer simply because of the multiplicity of agencies involved.

We worked with your director on how best we can coordinate the Federal programs and the State programs so we get maximum funding, maximum visibility, and in fact, enhance the basic dignity of the people who built the State.

A Priority of Spending Levels

The questions you are addressing yourself to today, as Governor Walker has pointed out, they are all germane, but we have to have a priority of spending levels, and we have to move forward. These barriers to Social Security have to be removed, so there is access, so the income is not cut by the inflationary cycle we are in.

A health service facility is no good if a person cannot get to it, so transportation is necessary.

We think if the scholarship program that we have will provide for the doctors, then the person in a rural area will not be cut off from the very specialized kind of medical treatment when they need it.

We think your continued interest in this area, and your total support is evidenced here today, in coming to Springfield, to highlight the need for movement, for movement now, for legitimate senior power is perhaps one of the major steps taken in the fight for decent health care for senior citizens in Illinois and across the country.

In closing, I would like to salute you today for the hearing here today and affording me the opportunity to participate.

Thank you very much.

[Applause.]

Senator Percy. I would like to ask you one or two questions if I could, but I would like you to comment on people later in life continuing their activities. I know having spent Mother's Day with my mother, I can reaffirm what music has done in her life.

It has been a wonderful thing with the great thrill she gets out of it and that she can give through it. She continues to do two or three concerts a month in senior citizens' homes, and has a full schedule ahead, and only looking around for more accompanists,

since she wears them out with the schedule she maintains. We are only reminded that Grandma Moses took up painting in her old age, because arthritis kept her from doing her needlework, so I think it is, therefore, not too late to begin a new fulfilling activity.

I was shocked when I went to the Federal Government and found how low in priority the needs of the elderly were placed.

We always put something like a war in vietnam, or education, or building dormitories, or all of these other things ahead of the elderly, who get what is left over. Now we have moved it over to a very high priority in the Federal Government.

In your judgment, in the State of Illinois, which has been such a leading State, what ranking in priority should the needs of the elderly have when it comes, for instance, to legislation affecting taxes, property taxes, for lower income elderly people? How high in priority, in your judgment, Governor, should be the needs of the elderly in the State of Illinois?

Lieutenant Governor HARTIGAN. I think it is clearly a matter of the first priority, because these are the people, the seniors of the States.

SERVICE FOR SENIORS—FIRST PRIORITY

We feel in this administration, Senator, that the questions of services for seniors should be of the first priority.

I pointed out in my testimony, these are the people who through 40 years of work and paying taxes have literally built and paid for the entire system that is benefiting everyone else.

I think that the seniors will be the first ones to support other areas of education, mental health, but by the same token, when we talk in terms of priorities, and we try to indicate that on the front of our report, whether it is housing, transportation, health, recreation, part-time employment, pension activity, preretirement training, nursing homes, nutrition, mental health, or income, virtually all of the questions representing our society, the people who have been paying are entitled to a decent return on that investment. So in working with Governor Walker, we felt the first matter that should be brought to the attention of the legislature should be in the questions of the services of the seniors, and that is why we are raising it to the Governor, to give priority status. And most importantly, I have gone to senior meetings in the time I have been in government, the one thing the seniors point out, and they are right, they do not want to simply be asked for their opinion, they are contributors, they have the capacity to do it themselves, and that is what we are trying to do here in Illinois with this concept of a senior director, seniors making a decision both on the programs that affect them and on the operation of those programs from an operational point of view as well.

Senator PERCY. In your own studies, what is the relationship between low income and poor health care?

We have for instance in this country about 3 million people living below the poverty line that are elderly, and when I say poverty line, I mean rock bottom $2,200 for a single, and $2,600 for an elderly couple.

To what extent have you found low income prevents the aged from getting the kind of health care they need?

Lieutenant Governor HARTIGAN. I think it is very extensive, and certainly these new proposals in the Social Security area are just aggravated that much more.

Our experience has been especially with the older woman, the woman over 65, who is single or widowed, that it is a very, very difficult situation, the lack of income, especially in this inflationary spiral, you have the fixed cost of rent, for instance, the fixed cost of the basic amount of food that is necessary. What is going to suffer?

Well, I think the thing that is going to suffer is the health care that is put off.

It is sometimes put off, and that is what I was attempting to suggest here, so that we get past the point where preventive medical treatment would sometimes delay much more serious kinds of illness, but by their inability to function through the lack of a decent level of income, the senior is put in a position of the consequences of a difficult long-term illness that in many instances could have been avoided.

I cannot see in our society, when we talk about the human element, when we talk about the dignity of the people involved, and we are talking of a $7.5 billion a year budget here in Illinois, how we cannot make it a matter of basic principle and right, that each citizen is entitled to a decent level of health care, and certainly if the inflationary cycle, if the lack of income is a barrier to them, we have to do something, and I think to do it now here in Illinois would obviate that situation.

Senator PERCY. I thank you for that unequivocal statement, and we thank you for your testimony and the leadership that you have provided, to what we consider, and I consider, a number one priority area.

Thank you very much indeed.

Lieutenant Governor HARTIGAN. Thank you very much.

[Applause.]

Senator PERCY. Now, Mrs. Margaret L. Summers. I have some questions I would like to ask of you, but we would like to have you make a statement, if you would like.

STATEMENT OF MARGARET L. SUMMERS, EXECUTIVE DIRECTOR, WHITE COTTAGE SENIOR CITIZENS, SANGAMON COUNTY, ILL., COSPONSOR OF THE SENIOR CITIZENS RALLY

Mrs. SUMMERS. First of all, welcome everyone to Illinois and to Springfield, and I do want to bring you greetings from Senior Citizens of Sangamon County, Inc., the instigator and cosponsor of Illinois first statewide senior citizen rally.

Senior Citizens is the grantee agency for three projects: LIFE—Local Involvement for Elderly—a 12-county area agency on aging for planning and service; RSVP—Retired Senior Volunteer Program*—to provide a meaningful role in valuable volunteer activities; and the White Cottage.

The White Cottage is a multipurpose, multiservice senior citizens' center, an affiliate of the National Institute of Senior Centers.

*See appendix 1, item 7, p. 349, Project LIFE case history.

While the topic for discusion is "Barriers to Health Care," the center movement offers many projects that fall into the category of preventive medicine.

While almost no one center has funds or manpower to provide all the possible services necessary as alternatives to premature institutionalization of older people, multipurpose centers can provide many of the alternatives and serve as catalysts in their communities for the provision of others. Studies indicate over one-third of the residents of nursing homes need not have been there if the local communities had provided the services necessary to keep them independent and at home.

Most basic is the function of a center as a place where lonesome, bored, older people with a low self-image can gather to find friends, a meaningful role through service projects, and friendly recognition.

In addition, centers offer counseling, referrals, and advocacy to help senior citizens solve many problems of living in their later years.

Telephone reassurance, transportation, escort, shopping service, homemaker service, home-health aides, home maintenance help, multiphasic screenings, friendly visitors, the whole battery of supportive services— or day care—or vacation care—or foster home care—and even legal, medical protective services—all help prolong the independence of older people with safety, security, comfort, and dignity.

Such services, though not all possible financially or staff-wise at present, do in the long run cost much less than residency in a long-term care facility, whether the costs are borne by the individual, the family, or the public—or $198 per month old age assistance, as opposed to over $500 per month in a nursing home.

Nutrition Project

Probably the most important single component in preventive medicine and in these alternatives is a nutrition project.

There is adequate evidence that senility—whatever that is—can be caused by malnutrition alone, and if this is the only cause, the condition is not irreversible.

Seventy-five percent of the deaths of older people are caused indirectly by malnutrition. The White Cottage is preparing an application for funding of a congregate meal project. There is a home-delivered meal system operative in Springfield.

Presently the White Cottage is not large enough to accommodate many functions and a larger facility is being sought.

The building is inadequate in many ways. Decentralization has proved inefficient in some ways and ineffective in others.

Specialized, individualized transportation for older people is coming, hopefully, in the near future, partially through revenue sharing funds.

In spite of many problems, we have a good operation. We are proud of the services we offer.

We thank you for holding this hearing in Springfield. We trust you will gain valuable insights into the barriers to health care from

a truly representative statewide group and some suggested solutions.

Have a nice day.

Senator PERCY. Thank you, Mrs. Summers.

I have just a few questions, and I would suggest that in a moment or two, while I am asking those questions, that Hon. John A. Davidson join us here at the platform.

I would like to ask you first about the changes that were proposed in Medicare.

These changes were advanced simply because it was the theory of those who advocated them, that if you have a deductible payment, you would thereby prevent or cause or discourage people from coming to the hospital if they had to pay something for it.

Do you think elderly people really want to go to a hospital?

Mrs. SUMMERS. Not really.

Senator PERCY. Do they seek it out, and would it discourage them from going if they had to pay something for it?

How much of a problem is overutilization among the elderly as a result of their wanting to go to a hospital?

Mrs. SUMMERS. No, certainly no one wants to, including older people, want to be hospitalized, and I do not think this is discouraging anything, because older people are not going to go unless it is necessary, and then it becomes a burden to have the deductibles.

Senator PERCY. In other words, some have bothered to talk to people and not just theorize about it, but find out for themselves that people are not seeking opportunities to go to hospitals?

Mrs. SUMMERS. Yes.

TRANSPORTATION: THE NUMBER ONE PROBLEM

Senator PERCY. You commented on transportation, and a surprising number of delegates at the White House Conference on the Aging mentioned this as a great problem, the number one problem many of them have. I think the figure is that 45 percent of them do not have their own transportation and must rely on mass transit.

It accounts for almost 10 percent of their budgets also.

In your opinion, to what extent does transportation pose a serious problem for senior citizens in obtaining health care?

Mrs. SUMMERS. You mentioned mass transit, and there are many who cannot take advantage of mass transit.

All of the people in the rural areas are not covered, fall in this category.

The same is true of those, as a common example, the persons with arthritis in the knees.

Our local Springfield busses have a bottom step of 14 inches high, and there are those that cannot board a bus even if it came to the front door.

There are others who walk to the bus stop, in inclement weather, so there is some really specialized type of transportation that is needed.

Cabs are the best answer, and there is not money of that kind, to pay cab fares usually.

Senator PERCY. Lastly, I think one of the most rewarding things I have done is engage in the Meals-on-Wheels program and gone out and delivered meals.

I choose cards at random without any prior announcement. When I walk in on a little apartment or hotel room, a woman looks up at me, and says, "Haven't I seen you before? Are you in the movies or something?" But I have found it a very rewarding experience.

Home Delivered Meal System

How important is the home delivered meal system to the health of the participants here in Springfield?

Mrs. Summers. I am sorry you limited that to Springfield.

We are not very proud of our program locally. It is not a subsidized program. It has been necessary to go to a commercial caterer. He charges $1.50 a meal. We do not always believe the first complaint on anything, so we wait, and when there are a sufficient number we send a counselor into a home where a meal was being delivered.

For $1.50, this recipient received meat gravy over a biscuit, a small dab of jello and a few green beans.

There has been no other arrangement possible in Springfield. We are hoping with a kind of meal setup, we can eventually take over this preparation and have a subsidized program that can help us.

Senator Percy. Do you feel in the order of priorities such a program is needed and that it is necessary to have a subsidized program?

Mrs. Summers. When they call in to inquire about Meals on Wheels, they do not have $1.50 a day to spend on a single meal.

They may have $1.50 for 2 days worth of meals, and so they actually cancel out.

There is a public aid allowance allowed for those on public aid, but the others who are not receiving public assistance have no help on this program.

We feel that the quality and the quantity of the meals would increase and improve, if it were included with another nutrition program.

Title VII does have some guidelines and basic requirements as far as what is served.

Senator Percy. I would think that the funding that we are going to provide now should support this program.

I can say it ought to have the highest priority from what I have seen, because the only resort that a person has, if he cannot have that kind of assistance, would be to say, "All right, I give up. I am going to move out; I am going to move into a nursing home." And the cost goes up from a few dollars a week to $400 or $500 a month, and it is for life, and he becomes a charity case. It is degrading to them, but they are trying to hang on, and Meals on Wheels many times enable them to do so in a way that is dignified, and in surroundings that they much prefer many times to a nursing home.

I think the idea of the kind of meals where you get the social services involved is more important to those who can leave their homes and go to a congregate site, rather than have a meal delivered in the home. But for those who cannot leave their homes the nutrition program is important to them.

Thank you very much indeed, and I thank you for the leadership you have provided in this whole movement, and for cosponsoring the senior citizens rally today.

[Applause.]

The committee extended an invitation to the President of the Senate to appear, and I am just delighted, and we are honored indeed to have Senator John A. Davidson appear today, representing the Senate of the State of Illinois.

Senator Davidson, we welcome you, and we are happy to have you give any statement you care to give.

STATEMENT OF HON. JOHN A. DAVIDSON, ILLINOIS STATE SENATE

Senator DAVIDSON. Thank you for this opportunity to appear before your subcommittee on health.

As a practicing chiropractic physician and former delegate to the White House Conference on the Aging, I have practical experience in the health care field and take a special interest in the particularly acute health needs of the aging.

Senior citizens as a group are particularly vulnerable to the stresses and anxieties generated by rapid change in a youth-oriented society.

They are clearly a low-income group that is highly susceptible to serious and chronic physical and mental impairments.

Consequently, they are highly disproportionate users of medical services and particularly dependent upon public assistance and public financing mechanisms to buy them access to the health care system.

They share with other age groups common barriers to health care but experience these barriers more acutely.

For example, I surely have no need to cite a litany of statistics to demonstrate that an inequitable distribution of health care resources in this country place Americans living in rural and urban core areas at a serious disadvantage in obtaining needed care.

For the aged person living in the inner city or predominantly rural areas of this Nation, health care is not simply difficult to obtain but often virtually inaccessible.

Along with other health care consumers, the elderly suffer from a health care delivery system that is crisis oriented and consequently over-relient on trauma management in institutional settings, while preventative and rehabilitative home maintenance alternatives to institutional care go unfunded and unexplored.

What for many citizens leads to unnecessary medical costs, results in many senior citizens being warehoused in institutions for the rest of their lives, simply because alternatives are not available.

CRISIS MANAGEMENT ORIENTATION

Furthermore, this crisis management orientation leads us to focus our attention and spend an excessive proportion of our health care dollar on the needs of a minority of our population being treated inside institutions.

Who is going to speak up for the majority of the aged who need home health and personal care services to maintain themselves outside of institutions?

Have we forgotten that a penny's worth of prevention is worth a dollar of institutional cure?

Summarily stated, our health care "system" is more interested in illness treatment than health maintenance, and overly dependent upon institutions to which the elderly must reach out rather than on institutions that reach out to the elderly.

The natural conclusion is that our resources and their needs do not link up. At the same time that we deliberate at the State and national levels about the need for "certificate of need" legislation, senior citizens in downstate Illinois are unable to obtain needed skilled nursing care.

Although a cost-conscious public is concerned about overutilization, inaccessibility is a grave problem.

Health care and financing of that care are so internally related that defects in care and distribution of care are often the result of improvident financing schemes.

Perhaps the cruelest irony is that Medicare, which was designed to guarantee the elderly access to medical care, has actually created gaps in medical service.

Medicare financing should be modified to provide coverage for home-health maintenance, preventative care, and outpatient services rather than institutionalization, whenever possible.

Furthermore, considerable thought should be given to moving away from a cost-reimbursement approach and towards a prospective per capitation approach to financing services.

The cost reimbursement approach, particularly the "reconciliation to costs" provisions of Medicaid and Medicare, destroys incentive to efficiently utilize existing scarce medical institutional resources.

Furthermore, the cost reimbursement approach leads to excessive redtape, burdening both the providers and users, as well as a bureaucracy that is so concerned with cost accountability that it promulgates preposterous regulations governing service delivery and reimbursement.

Let me give you an example.

Recently chiropractic services were declared eligible for reimbursement under Medicare, and just recently in Illinois under our Medicaid program. However, regional officials of the U.S. Department of Health, Education, and Welfare in Atlanta have stated that they are not going to reimburse for X-rays that the law requires to demonstrate the need for medical treatment.

What kind of impact is such a regulation likely to have?

Clearly it is counterproductive to the goal of Medicare as originally conceived and hardly likely to render care more accessible with the result that a condition easily remedied may lead to institutionalization.

If comprehensiveness of care and continuity of care are to be achieved, our public financing systems, whether they be Medicare, Medicaid or one of the various proposed national health insurance programs must provide appropriate incentives to provide such.

Furthermore, third-party payers in the private sector should be encouraged to standardize reimbursible benefits, or to guarantee comprehensive services through an HMO approach, to meet the needs of workers in the 55–65 bracket and middle-aged members of the mid-

dle class, who are ineligible for Medicaid and Medicare, yet unable to meet costs of catastrophic illnesses to which they become more susceptible with advancing years.

Cultural Environment

Finally, we could hardly speak of health barriers to the aged without some mention of their cultural environment, and I think this last paragraph gets to many things you talked to Mrs. Summers about.

If health has anything to do with a sense of well being, we can hardly maintain the health of senior citizens without providing them with the means to achieve a satisfying and meaningful integration into the social and cultural life styles of their communities.

Surely few human experiences hold larger consequences for us than the experience of aging, yet if there is a predominant cultural attitude towards it in American society, it is to deplore aging and the aged.

Perhaps that is the greatest health barrier senior citizens face, and one which every citizen can join hands in attempting to overcome.

This pretty much covered the points which we have facing us in the legislature, and if there are some questions, I would be glad to answer them.

Senator Percy. I have a couple of questions.

I wonder if Mr. Floyd E. Galliher would join us at the table now.

Senator Davidson, first of all thank you for your leadership in this field.

You have been very active and outspoken in this area.

I will put the same question to you that I put to the Governor and Lieutenant Governor: How high in priority do you think the needs of senior citizens should be when it comes to State resources and budgets?

Senator Davidson. Well, it has to be a high priority, and then we get into the difference of high priority to meet the cost, and in senior citizens situations, we have a high priority demand to help reduce the real estate tax load on them, which I think is correct, but at the same time, we have the demand to making services available, which resources must be bargained for.

This is what we are trying to balance out. As far as I am concerned, the need of preventable care for senior citizens is of the utmost priority.

Senator Percy. Many of those people carried the load when you and I were young men and young ladies in the heart of the depression and brought this country from out of the depths of despair and made us what we are today, and we have an obligation to fulfill the needs of these people, espcially considering what they did for us.

You were a delegate to the White House Conference on Aging, and as I attended those sessions, there was a great deal of effort to strengthen Medicare, such as extending coverage to include drugs, eyeglasses and dentist care.

Improvements Needed in Medicare

What improvements do you feel are needed in Medicare?

Senator Davidson. I think a combination of all that you mentioned, the part that I was involved in, only by reading the reports, the parts that you mentioned, I am aware of.

I was involved in the nongovernmental units, but the cost of drugs, particularly the cost of drugs for a person who is on a fixed income, to go down to the local drugstore, to purchase what he needs to maintain himself is a real burden to him.

In fact, many times he has taken food out of his mouth to meet the costs.

This has to be done, and I think a person who has a hearing impairment should have some help, and if a hearing aid will help him, then he can be a useful member of society.

I think the most important thing we have to stress, that is for senior citizens, and I have a father who several years ago who I said to slow down, he said, what do you want me to do, rust out. Remember, on the farm, when you set it out, set out the machinery in a corner, it rusted out, as long as you used it, it lasted.

I think the thing is that senior citizens are participating on civic projects to make them useful, and as long as they are useful, we can make good use of their talent, and we have done it.

Senator Percy. I have to tell you, Senator, about a hearing we had in Washington. The front page of the Washington Star that night had a picture of Senator Frank Church and myself with the caption, "Young Old Fogies Learn What It Is All About."

We had doctors appearing before us, and, the staff will remember, telling us about, and showing examples of some of the problems of aging.

For instance, the doctors came up with a pair of smoked glasses and handed them to us, and said, "Put these on, Senators, and you will see how obscure your vision becomes, that things get fuzzy later in life."

I said, "Wait a minute, doctor, you try my glasses." He put them on, and he said, "Oh my heavens, they are worse than the ones I just gave you."

He said, "Here are wax plugs to put in both of your ears, because when you put them in, you will understand what it is like to have a loss of hearing.

"You just cannot hear words as distinctly and as clearly."

I said, "Why do you think I have this hearing aid on?"

I was a gunnery officer. I lost part of my hearing, because of the excessive noise.

We know what some of those problems are. I always thought until I got this hearing aid that it was just that people were talking more softly, and they were muttering their words. Finally my wife convinced me, "We are all speaking up; you need an assist."

High Cost of Hearing Aids

I was shocked at the cost of hearing aids. It is unbelievable. How people on low income could afford it, I just do not know.

I have tried out seven or eight different devices to finally find the right one, and it is a very costly process. But to think for a few hundred dollars, that we could not provide an individual with the ability to communicate with his fellow man. I have had a great assist, particularly on the floor of the Senate, where it is very hard to hear anyway. I feel very deeply about these things, and I appreciate your comments.

One last question: Women retire and get Social Security benefits at the age of 60, but they do not receive Medicare benefits until age 65.

Do you have any judgment, Senator, on some of the suggestions that have been made, for example, that the elderly should have concurrent benefits in Social Security and Medicare, that whatever benefits one gets on Social Security, ought to extend over to Medicare, that women ought to be eligible at age 60 for Medicare?

Senator DAVIDSON. Yes; I have a feeling in the part about 60, 65, physically, I cannot address that point.

The point, I think, which is well taken by them, and I feel if a woman has participated, and has paid her fair share into Social Security and/or Medicare, then she has the same fair share right to participate for full benefits, not because she should be fortunate to have a husband living, should she be cut down on her share, or vice versa. This was brought to my attention, that a women—the widow was not able to participate in the benefits—in fact receives less than the widow share.

If they are paying their fair share, like you are paying your fair share in insurance, you have a right to cover that amount.

Senator PERCY. Senator Davidson, I thank you for being here.

If you will convey my best intentions to the President of the State Senate, I would appreciate it.

Thank you very much.

Senator DAVIDSON. Thank you, Senator.

[Applause.]

Senator PERCY. Our next witness is Mr. Floyd E. Galliher, president of the Illinois State Council of Senior Citizens Organizations.

We are honored to have you here, Floyd. We would be happy to hear from you, and I have a few questions for you.

STATEMENT OF FLOYD E. GALLIHER, PRESIDENT OF THE ILLINOIS STATE COUNCIL OF SENIOR CITIZENS ORGANIZATIONS

Mr. GALLIHER. Thank you, Senator.

[Applause.]

As president of the Illinois State Council on Senior Citizens Organizations, and on behalf of over 400 affiliated clubs, I welcome the concern of the Senate and I am pleased to place before you some of our concerns with regard to health care for the aging.

The health needs of our people over 60 years of age differ from the needs of other people only in the magnitude of their needs.

We invite your concern for our health problems as a part of the overall health care problems that confront the whole of America, good health after an individual becomes 60 cannot merely be a prod-

uct of possible health care advantages established singularly for the aged; rather good health for a person over 60 will come from his lifetime of good nutrition, good health habits, and good medical care.

Good health care is comprehensive care that is preventive; maintenance health care is health care for the critically ill.

Good health care is health care which is accessible from the standpoint of transportation and of cost to the consumer.

Good health care is health care that integrates both the concerns of the health professionals in their objectives for quality care as well as the concerns of the consumer for the accessibility of health care.

As a resident of Madison County, Ill., I can speak most authoritatively about the needs of the aging and about the availability of health care resources to accommodate those needs in my own community.

But I can state generally that the concerns, the needs, and the resources of my home county are not particularly unique.

In Madison County some 34,000 residents are over 60. Of these, more than one in four are poor.

About 30 percent of them receive old age assistance. To this group, income is limited to the $160 a month they receive.

And although the income needs of the elderly constitute a problem of its own magnitude and import, it is a problem that is germane to a concern of health care to the elderly.

Because such a large number of elderly live on marginal incomes, access to proper medical care is sometimes through a resort to public assistance.

Of course, not all of the elderly in my home county are technically poor, but this does not mitigate the fact that most people over 60 are confronted with the problem after retirement of maintaining their life style, their property, and their health with substantially reduced income resources.

Medicare for this group has provided some balance against the problem of low income and high medical costs. But Medicare has its drawbacks on which we will elaborate later.

Lack of Health Care Resources

In my community a major obstacle to availability of good, comprehensive, health care is a lack of health care resources.

By that I mean there are simply not enough doctors, not enough hospitals, not enough health clinics, nor is there adequate transportation.

At the 1973 national health forum, the general theme revolved around there being a surplus of doctors. This is not obvious to me.

In my own home town of Alton, there are fewer doctors today than there were 10 years ago. In my home county with a population of 251,000, there are only 75 physicians, that is one doctor per nearly 3,300 population.[1]

[1] Source: State of Illinois Survey of County Needs and Resources Related to Older People, table 5.

I have heard it argued that the surplus of physicians is localized in the urban areas, that the problem is not the number of physicians, but distribution of physicians.

But, Honorable Senator, though I am an unlearned person in economics, that does not make sense. I know enough to argue that when there are surplus commodities, costs of commodities should decline.

Yet this is precisely in the urban areas that health care is the most costly. Even in my own areas which is partly urban, partly rural, health care is not cheap.

A hospital bed costs $81 a day. That $81 represents a sizeable portion of income of all groups of people over 60.

And although $81 is the cost of a hospital bed for 1 day, because the health care needs of the elderly tend to be greater than the needs of the rest of the population, it is precisely the older person who will use the hospital bed the most.

It occurs to me that possibly one reason the cost of the hospital bed is so high, if my community is an indication for the rest of the county, it is because there is only one bed for nearly 250 people.

Accessibility of Health Care—Transportation

Yet there is another factor in the accessibility of health care for the elderly, that is transportation.

Although most people after 60 attempt to continue a life that is active and unencumbered, there comes a point when the use of one's personal automobile becomes part a luxury and part a risk.

It becomes a luxury because of the ever rising costs of maintenance, insurance, and gasoline.

It becomes a risk because with advanced age one's eyesight begins to fail and one is not nearly brave enough to get on today's highways.

But in many areas, including my own, there is no readily available alternative to personal transportation.

Again take my own Madison County. Bus transportation is highly irregular and is designed not to link people with local community stores and resources, but the local bi-State authority links small communities with metropolitan St. Louis.

Such a transportation system has little relationship with our people's needs to transportation a few blocks to see a physician or pick up a few groceries.

And when someone wishes to utilize this transportation system it is discovered that the cost is high and the time involved is long and the trip is tedious.

The alternative to the bus is the taxicab, and that is no alternative for a person over 60 living on a marginal income.

Any proposed plan to upgrade health care for aging must provide the linkage of the health care system and the transportation system.

Thus far we have discussed broadly what we mean by good health care, and we have generally outlined the barriers to good health care to be:

(1) Lack of consumer input to health care policy.
(2) The marginal income of the elderly.
(3) The lack of consumer health resources.

(4) And the need for a transportation system linking the community elderly with community health care resources.

On these obstacles to good health care, I have some observations and suggestions which I submit for your consideration:

First, I applaud this Senate subcommittee hearing in that it represents an attempt to register consumer interest and concern in health care.

Too long, only the interests of the medical professions and of the insurance companies have been acknowledged by policymakers.

We would like to see this experience in which the policymakers confront and listen to the people who are affected by legislation. Contrary to some elite thinking, we do not know what we need, and what is to our benefit.

Second, although Social Security and Medicare are extended to a large sector of this country's aged, these programs are limited.

They are limited in that they still do not extend coverage to all in need.

As there are poor people in the population as a whole, there are poor among the aged.

This group has no articulate champion of its needs. We believe that the needs of the elderly poor should not be separate from the income needs of all the poor.

Income maintenance is one long-term, although controversial, solution to this need. As those of us who are not poor can testify, income is not enough to secure proper health care.

Third, attention must be given to the available health resources.

Not only are more doctors, more hospitals, and more clinics needed, but a better distribution of these resources are needed.

Availability of Health Care

Availability of health care also means access to health care, ideally through a national health insurance program, such a program should encompass not only the aged, but the young, the poor, and the average citizen.

You see, an objective of good health for the aged assures a healthy individual throughout his lifetime.

Increased health care resources should include methods by which the aged are directed away from hospitals and long-term institutional care.

This means that good health care should provide for home and neighborhood health care.

In this, comprehensive medical prepayment may play an important role. However, it is significant to note that no such groups are available in Illinois, as present State laws restrict this type of practice.

Fourth, a national policy on health care for the aging must include a policy on transportation.

Transportation which is economical and readily available must link the people in need with the resources to provide for those health needs.

Senator Percy. That is a very fine statement, very comprehensive and helpful.

[Applause.]

Mr. GALLIHER. Thank you, Senator.

Senator PERCY. I would like to get some idea of the cost per capita of the elderly for health care in central Illinois.

Nationally we know that average health care expenditures are almost $1,000 a year for the elderly, which is seven times the amount that a person under 19 spends, and three times as much for all of those people from 19 to 64. So it is a very high element of cost and a very high proportion of the budget.

Do those figures approximate what the actual cost for the elderly in central Illinois is?

Mr. GALLIHER. Senator, it is rather hard to come up with an exact figure on this.

We figure that in the neighborhood of $700 is about the figure of our average in this area.

MEDICARE INCREASES

Senator PERCY. The deductible for hospitalization was increased from $64 to $72 in January, and the deductible for doctor services under Medicare was boosted from $50 to $60.

Have these increases in your judgment deterred the elderly in Illinois from seeking out any care, whether it be physicians, hospitals, or otherwise, which they might otherwise need?

Mr. GALLIHER. We are sure that this increase in Medicare is certainly going to decrease the availability of medical service for the aged.

There is no question about it. It is this policy which injures on the fact they are putting the policy directly on the patient himself.

Now, very few patients are going to say, do I need this additional day in the hospital, can I get out a day earlier, do I need this test.

No, no patient in the hospital wants the doctor to skip him on the care he is going to get to make him well. This certainly is not the case. We certainly know that a lot of people, when senior citizens wake up in the morning with a headache, and they begin to wonder, is this the day, and they begin to look at the money available, and the individual knows if he goes to a doctor's office, this will cost him $10.

If the doctor says I think we should run some tests, he knows that possibly the minute he opens a hospital door, this will cost him in the neighborhood of $200, and he thinks twice. I think it is a fallacy to say that the average person, or the senior citizen is anxious to see a doctor, or to even become a patient in a hospital. We think it is absolutely the reverse.

Senator PERCY. And finally—and I would suggest now that our senior citizens panel, Mr. William L. Chapin, Mrs. Lucy McAdams, and Mr. I. D. Mueller come up to the podium and the platform—what role do you think the homemaker and home health services should play in a national policy to develop alternatives to institutionalization?

Mr. GALLIHER. Senator, you have been in industry, and you know that industry does not provide preventive medicine, preventive maintenance for its equipment soon falls by the wayside, and the dividends fall off, and the result is we have a loss.

We think that preventive maintenance is one of the most important things that senior citizens need, that could be made available to them.

We think the neighborhood health center should certainly be developed.

We think that many people could stay possibly out of the hospital a day, and maybe get out of the hospital a day early, if there was someone who could call on them to be sure that everything is all right, and that could analyze the situation, we think that home health aides, and homemakers could do this.

We think that we are derelict in pushing forward a paraprofessional program.

We think there is a big need for many of the people who have this type of training that are now being shunted out into other industry.

We certainly think there is a dire need for this kind of thing.

Paramedical Personnel

Senator Percy. I presume you would agree with me on the shortage of medical personnel which you mentioned, that if we improve the utilization of paramedical personnel for doing the kind of duties they can perform, and do not require a trained doctor, or a trained nurse, even a dentist, that that would help? Is that correct?

Mr. Galliher. I am sure this is correct. I think that we are actually practicing, the doctors in some extent are practicing some type of care.

A doctor does not feel that it is necessary for him to be in the presence of a nurse who is giving a shot. We think that these people, registered nurses and paraprofessionals certainly have the qualifications to analyze the condition of the person and determine to a great extent whether they should be seen by a doctor or not.

Senator Percy. The figures you gave for Alton are duplicated in Chicago.

We have fewer doctors residing and practicing in Chicago than we had in 1931, and we have a lot more people in the Chicago area, and we have a great problem.

I think you have helped us enunciate it, and we thank you for your leadership and guidance in this field.

Mr. Galliher. Thank you very much.

Senator Percy. We will now hear from the senior citizens panel, represented by Mr. William L. Chapin, vice chairman, Mayor's Senior Citizen Commission; Mrs. Lucy McAdams, Springfield, accompanied by Mr. Dennis Palys of Project LIFE [Local Involvement for the Elderly], Senior Citizens of Sangamon County, Inc.; and Mr. I. D. Mueller of Bluffs.

We appreciate your being here to accompany Mrs. McAdams, Mr. Palys.

I have a few questions for all of you, but if you would like to make some brief opening comments, we would be happy to have those comments, or if you would just like to use the question period, we can do that.

STATEMENTS OF THE SENIOR CITIZENS PANEL, REPRESENTED BY WILLIAM L. CHAPIN, VICE CHAIRMAN, MAYOR'S SENIOR CITIZEN COMMISSION; LUCY McADAMS, SPRINGFIELD, ACCOMPANIED BY DENNIS PALYS OF PROJECT LIFE (LOCAL INVOLVEMENT FOR ELDERLY), SENIOR CITIZENS OF SANGAMON COUNTY, INC.; AND I. D. MUELLER, BLUFFS, ILL.

Senator PERCY. Mr. Chapin, I will say that you are not just a friend but an old friend of long standing. We are ready to hear from you, Mr. Chapin.

Mr. CHAPIN. Thank you, Senator Percy.

They say a lobbyist is a fellow that has been paid a magnificent salary to go before the legislature or Congress to try to promote a bill that is for his organization or his company.

I am an old man, in fact I am so old, that sometimes I think you have to be half senile to want to go over and lobby for nothing for senior citizens, but I enjoy it.

Since I have been active in the Illinois Legislature I find that senior citizens every place want bills passed that benefit them. Moreover, we, the senior citizens of Illinois are very much interested in any bill that will reduce our taxes.

Naturally, it will be a bipartisan bill, because in Illinois, you cannot pass a bill unless you get bipartisan support.

I might say, that here in the Illinois Legislature we are getting so many bills introduced, that nobody can keep up with even those that are concerned with the problems of senior citizens.

Since I have been interested in doing this kind of work, our senior organizations get complaints from seniors all over the State and wanting us to try to get bills passed, as they put it, they want to save taxes, but what they really want is to save on taxes so they can buy more nutritious food, medicine, and other necessities.

They do not want to save taxes to put some money in the bank.

I had a couple of bills that I would like to briefly mention here, in the house, that started out as bills for one thing, and they turned up to be bills favoring nutrition, medicine, health care.

REDUCE THE STATE SALES TAX

One was a bill that recently came up in the Illinois House in one of the committee hearings to reduce the sales tax by about 50 percent on food and many medicines.

Now, this tax applied to all residents of Illinois.

[Applause.]

I do not know what that is for, but anyhow——

Senator PERCY. As a politician, I can tell you, it is not disapproval of what you said.

You would not hear it if they did not agree with you.

Mr. CHAPIN [continuing]. Ordinarily you would look at this bill, and say if it was for all citizens, it would not be of value to older citizens, but the sponsor of this bill said you testify for it.

I said it is more beneficial to senior citizens than anyone else. When you get a 50 percent reduction in sales tax, the senior citizens with

their income, a larger part of it goes to food and medicine, so they benefit more by this than anyone else from this particular tax situation which has now passed the house, and may get into the senate.

I testified for this bill, that it would, as I said, benefit the senior citizens more than any group, because senior citizens, particularly in the low-income brackets, spend more of their income for food.

50 Percent of Income for Food

I think sometimes the average amount paid for food is 25 to 30 percent. I think senior citizens sometimes pay 40 and 50 percent, and when you think what their income is, $1,500, $2,000 a year, think of what a chunk that is out of their income.

Now, I said another thing, not because I said it, but senior citizens do not buy the most nutritious food. They buy the kind they can afford. The second thing is that senior citizens would rather starve than ask for help from public aid.

Many senior citizens want to keep their self-respect, and that is more important to them than to go begging for food.

I think that is a very important item. We do not think it is true until we go out and talk to some of these people, and say, "Why don't you go to public aid for help?"

Why, public aid, I would not go near it.

To put it this way, we old people have our self respect, and we want to keep it. Then the committee member asked the sponsor of the bill how a checkout girl would check out the food items, keep them separate, and the sponsor replied any girl ought to be able to check out food items, that any food for human consumption would be very easy to pick out, and then he made the statement she ought to be able to pick out a can of cornbeef from a can of dogfood, and I had to say something about that, and I turned to the sponsor, and I said, "You will have to include dogfood in this bill on food, because many senior citizens are eating dogfood."

Now, incidentally, dogfood is not a poison. It tastes good. It has a lot of protein, it costs about 10 cents a can instead of 50.

The funny part of this was when the hearing was over, three of the committee members said, "Where did you get that idea of dogfood?"

I said, "You go into a supermarket, particularly in the poor areas, watch the senior citizens buying food, and just ask what a poor old lady is doing with 10 cans of dogfood."

She does not have 10 dogs, and like one lady, I asked her, "What do you do with all that dogfood?"

She said, "I feed my dog."

I finally made a remark, "It does not taste bad," and she said, "No, it does not taste bad," and it was the giveaway that she was eating it.

Another thing that we find every place, this goes back to the bills I was talking about where in Illinois, New York, California, you will hear this down in Congress, the senior citizen's money is nearly gone, and then he starts to cutting down on food, and he has already cut out medicine, and he has already cut out doctor bills, and one other thing, I can mention many things that happen over here that

reflect back on the question of medicine and nutrition, another thing that is very much in evidence here in Illinois, senior citizens use the homestead tax exemption or refund of some kind on taxes to pay for better food and medicine.

I think in Congress, as you were just discussing, a Federal refund on real estate taxes, when a tax bill is 20 to 40 percent of a senior citizen's income, in other words, $300 out of $1,200 or $1,500, what is he going to do?

Illinois has a $1,500 tax exemption. It has the circuit breaker bill, all of which help our senior citizens but I would say this, right here in Illinois at this particular moment, I bet there are two or three sheriffs standing before the doors of some poor citizen getting ready to take over his house, probably an old unsalable house, and set him in the street because he cannot pay his taxes.

To my mind the cost of setting people in the street is a whole lot greater on the public than giving him a tax exemption, a tax refund, whether it is in Congress or here in Illinois.

One other thing, I am only touching on the nutritional program, covering hot meals, I think it is a good idea, I still think we have to look at the dignity of older people.

Several people asked me, I think maybe you did, how many people can we expect in these programs.

My guess is as good as anybody elses. My guess is they would have to start slowly. I think we have to get away from the dole. If senior citizens think they are on a dole, they will not accept free meals just because the Government is paying for it.

I understand we are going to try to put a price on those meals, very low, but anything under the sun besides dole.

If they are going to come, let us not make it charity, and we will get more response.

In closing, I would like to say I commend your subcommittee for coming here to Springfield. I am glad you came down to the grassroots. I think a lot of you Senators are doing a lot harder work than anybody knows. I have been down to Washington a number of times. I know something of what you do down there. I think when you come out here, you give the senior citizens of Illinois a better idea of what you are doing for them in Washington.

I say the same thing for our Illinois legislators. We have a lot of fine legislators over here. I would like to commend them the same way. I am mighty glad you held this hearing.

[Applause.]

Senator PERCY. Mr. Chapin, your prepared statement will be placed in the record of these hearings.

Mr. CHAPIN. You have the prepared statement.

Senator PERCY. We will incorporate that into the full hearing record.

[The prepared statement follows:]

PREPARED STATEMENT OF WILLIAM L. CHAPIN

Mr. Chairman, I am W. L. Chapin, I am vice chairman of the Springfield Senior Citizens Commission.

I am also a volunteer senior citizen "lobbyist" in the Illinois Legislature helping to get legislation enacted that will be beneficial to our Illinois senior

citizens. Naturally, such benefits are in areas of income, health, housing, et cetera.

Therefore, it would seem to me that my testimony before this U.S. Senate Committee would be more valuable if I confined my testimony to a field in which I am somewhat familiar. I would like to show how so called nonhealth bills pending in our Illinois General Assembly are directly related to health care of our Illinois aged and how they will remove the "barrier" to such care.

As one example—a bill recently passed by the Illinois House (House Bill 634) will reduce the Illinois sales tax about 50 percent on all food and many medicines *for all Illinois residents.* But, this bill *will benefit* senior citizens *more* than any group, *particularly* those in the low or middle income brackets. Why? Because such senior citizens spend a larger part of their income on food and medicine (25 percent versus 30–40 percent). Nutritious food and medicine are vital to the health of senior citizens. A reduction of the Illinois sales tax on food and medicine would save the average low income senior citizen from $1.50 to $2 per month which he could use to buy an extra pound or more of hamburger even at today's prices.

At the committee hearing on this bill, I testified that—in my opinion—most low income senior citizens *do not* buy the kind of food that is most *nourishing, but* they buy the kind of food *they can afford.* I further testified that—in my opinion—many senior citizens would live on a starvation diet before they would go to public aid and ask for help. Their dignity and self respect is more important to them than nutritious food that they have to "beg" for, as they see it.

Our Illinois Legislature is greatly concerned regarding the plight of our Illinois senior citizens. But they can only vote responsibly and intelligently on senior citizen legislation when we seniors give them information and facts about our problems. Recently, a concerned Illinois legislator asked me if I really thought that any Illinois senior citizens were "starving to death." He was most grateful when I explained that a *much worse malady* called *malnutrition* was found to exist here among senior citizens far more often than was expected.

I might give one more example. Most States have some form of homestead tax exemption for senior citizens. At present, Illinois exempts $1,500. The most important reason to give this tax exemption to senior citizens is to help enable such senior citizen to live in his own home as long as possible. There he lives in familiar surroundings. He can cook his own food in his own way. He can have his own garden and fruit trees to supplement his meager income. He can "putter" around. And, as a result, he remains self-sufficient—he maintains better health—physically and mentally, and he postpones the day when he might become a public charge in a nursing home or the hospital.

About 2 years ago, I called on a widow here in Springfield who felt that her sewer tax was too high considering the small amount of water she used. She lives alone in her own home. Her house is too large and in need of repairs. There is no market for such a house should she want to sell it. But, she would not be happy anyplace else.

Her husband died several years ago after a long, expensive illness. Her present income is only her Social Security plus a small pension. However, she supplements this income from her garden and some peach trees. Her basement was full of canned vegetables and fruits. And, her homestead tax exemption almost offsets her taxes and this run down house. But, she is *happy here,* and *her greatest worry* is what she would do if she had to give up her home.

Today, the biggest complaint we hear from healthy senior citizens is high taxes. And, their greatest worry is what will happen to them if their money runs out and they may become public charges. Today, many senior citizens can only buy the bare necessities of life with their meager incomes. The only place left to cut their expenses is on food. They already quit buying needed medicine.

The result is that malnutrition and health problems among senior citizens are becoming more acute. As I have tried to show, more tax relief by both State and Federal governments on food, medicines, and homes will give our senior citizens more money to spend on nutritious food and well balanced meals. Such tax relief *will not* solve the many problems of our aged, but it is *one more step* in the right direction.

Senator PERCY. Mrs. McAdams, we would be happy to hear from you, and we are pleased that Dennis Palys of Project LIFE, Local Involvement for Elderly, is here with you.

Mr. PALYS. Senator Percy, Mrs. McAdams is 75, she has been a widow for 30 years, and she lives alone.

We have prepared a few questions here to introduce Mrs. McAdams. She has a statement, and then you can ask some questions.

Mrs. McAdams has an illness called Parkinson's Disease, it is the common term. It affects the central nervous system.

Mrs. McAdams, could you tell us the biggest problem you face because of this disease?

Mrs. MCADAMS. Lacking muscles. My muscles do not coordinate, but I try to walk from about 10 o'clock until I go to bed, and I do manage some, and I also have to get out with the walker.

Mr. PALYS. Do you take medicine for this?

Mrs. MCADAMS. Yes, I take medicine for it.

Mr. PALYS. How much do you spend on this?

Mrs. MCADAMS. $18. It is $18.40 a month.

Mr. PALYS. And does Medicare cover this?

Mrs. MCADAMS. No.

Mr. PALYS. What is your total income?

Mrs. MCADAMS. $83.20 a month.

MEDICINE—22 PERCENT OF INCOME

Mr. PALYS. This is her Social Security income, the medicine is a full 22 percent of her income.

Have you ever used Medicare coverage before?

Mrs. MCADAMS. Yes; I have.

In 1971, January 7 to March 7, and that was because they put me in the hospital, and put me on this new medicine, and it paralyzed me.

I did not have anyone at home to take care of me, so they let me stay in the hospital for 2 months, and it cost about $4,000.

Mr. PALYS. And how much of this total bill did you pay?

Mrs. MCADAMS.. I did not pay the hosptial bill. I just paid part of the doctor bill, which was $180, I think it was.

It was a bill I had to pay.

Mr. PALYS. And when was the last time you have seen a doctor?

Mrs. MCADAMS. There is nothing that they can do for me.

All I can do is take this medicine, and I manage about once a year for an examination, and that takes about $50 or $60, and on my $83, I can only afford to go about once a year.

Mr. PALYS. And can you tell us what your most pressing need today is?

Mrs. MCADAMS. Well, I guess more Medicare. I do not see how they can help me, and I take the Meals on Wheels, because of my inability to take care of myself, and that takes about $55 a month for food.

Mr. PALYS. Senator Percy, it costs $30 for meals plus her own separate food.

Mrs. McAdams. I need two extra meals, for Saturday and Sunday of every week. The Meals on Wheels, this comes 5 days a week, and that is $30 a month.

Mr. Palys. Is there anything else?

Mrs. McAdams. I would like more Social Security if I could have it.

Senator Percy. Thank you very much, Mrs. McAdams. We will have our final statement, and then I will have a few questions for each of you.

Mr. I. D. Mueller.

STATEMENT OF I. D. MUELLER, BLUFFS, ILL.

Mr. Mueller. Senator Percy, I come from one of the smallest counties in the State, Scott County, a rural county.

We only have a population of 6,096, 22 percent are considered elderly, 17½ percent are over 65, and we have one doctor, and transportation is one of our problems down there, in a rural community, and housing is another problem.

At the present time I happen to be on a housing committee there, and at this time we have 29 applications that are urgent for more housing for the elderly, and the malnutrition proposition down there, we had a report recently of some taken to the hospital for malnutrition.

The administration of the hospital said they could not call it directly malnutrition because they had plenty to eat in their home.

The doctor I talked to on this said that malnutrition in Scott County is a person's own thought, and then he went on to say it was a person's own fault, and then he went on to elaborate, he said the elderly did not cook their own meals, and eat like they should and eat the proper nutritional foods, and that they are needed to be some visitation or help in that regard.

The transportation proposition is getting these people to the doctor, and we do have a number of people, and this is repetitious of some of the things said here, we do have a number of people living on small incomes, and they will not go to the doctor because at the present time it costs them $7 to $10 a trip to get to the doctor, and that is about 35 percent of our elderly that have to depend on someone else to get to go to a doctor, and there is only one in the county, only one doctor, and it is a problem in that respect.

I think they could use some assistance down there. You cannot get enough people to volunteer to go into these homes, and I think we need some help down there for transportation and all.

Senator Percy. Do you have a high school?

Mr. Mueller. Yes. We have two high schools in the area.

Senator Percy. You know, I wrote every high school in Illinois, and every nursing home, and told them about the experiments we have been running up on the north side of Chicago where college campuses and high schools have provided volunteers.

Drug Abuse Among Older People

Drug abuse is very high among older people, and it is very high among young people, because they do not feel needed. They do not feel wanted.

They sort of cop out on drugs, and it seems to me we could combine the two groups. Young people need to feel needed, they want to feel important, and they do not get into the mainstream of life early enough. So we had young people from high schools and college campuses go over and with the young girls, go in and help comb the hair of the women, help them write letters, help them with phone calls, read the daily newspaper to them.

You know, after 3 or 4 weeks of this, just once or twice a week, I found the people in the nursing homes dressing up for the young people to come in.

They would invite them to try to stay to have a cup of coffee or something like that with them. They started calling them my "grandchildren," and I noticed the younger people calling them "grandpa" and "grandma."

A close working relationship developed there, and the young people were tremendously helpful and useful in doing many, many things that were not done. The whole tone and attitude was more cheerful, more bright. It fixed things up, and it was a marvelous thing, and it did not cost the Federal Government a penny.

Now, is that a possibility in Scott County?

Mr. Mueller. I would think that would be, Senator Percy.

I do not know if it has ever been mentioned. Our superintendent of schools down there, I have never heard him mention anything like that.

If he got the letter, possibly it went into the wastebasket.

Senator Percy. I wonder if you could go into the high school and give them the message for me, and possibly the social studies class, and just see some of these young people say, "It makes me feel 10 feet tall; I feel useful; I am doing something that is important," and it is a wonderful thing.

I really recommend it to any groups that need to be brought together that way, and what I like about it is that it is not the Government, it is people-to-people, and that is important.

Mr. Mueller. There are a few of us down there, Senator Percy, we are buying an ambulance.

I work with the senior citizens group, we have been trying to get something worked out for a number of months.

I know we mentioned the drug deal, I happen to know one particular person who does not go to the doctor because the costs are too high, but he absolutely lives on aspirin which those are the things we know about.

Senator Percy. Well, we are just very pleased to have all three of you, and the questions I have will just be to try to expand a little bit.

Mrs. McAdams, let us start with you.

I hope you can dispel the belief that so many people in this country under Medicare have no expenses.

It has been a shock to me to learn that because of costs of people 65 and over today, in dollars they pay more for medical expenses than they did when the Medicare program began.

Continuing Medical Expenses

Today Medicare covers 42 percent, and in your case, you can simply certify that despite the fact that there is Medicare you do have continuing medical expenses that either are taken away from other areas of expenditure, or you simply cannot meet.

Mrs. McAdams. Well, I meet it, but you have to take away from other things, like lesser food and no transportation.

I cannot afford a cab, no recreation, there is nothing in Springfield, I have called every one that advertises for the senior citizens, and they say no, we have nothing for you, and I like to go on the bus rides that they sponsor, but there is no one to help me on the bus or off the bus, and I do not have enough Social Security to pay.

Senator Percy. I wonder if you could just comment on Dennis being with you today. Would it have been possible for you to be here without Dennis?

Mrs. McAdams. No.

Senator Percy. And do you have a feeling you have a friend in life?

Mrs. McAdams. Yes, if he stays here, and if you keep employing him.

Senator Percy. Dennis, I wonder if you would mind commenting on how you happen to be performing this service, or how it gives you a sense of being, of service in the Socratic search for happiness?

Socrates said we all try to search for it in some way, spend money, go on vacations, buy things.

Socrates said long ago that no form of true happiness other than through service exists.

Is that what you found?

Mr. Palys. Well, basically, yes, Senator, but my original meeting with Mrs. McAdams came when I was doing some volunteer work during my applied studies.

I have an interest in aging, and in the terminally ill. Working with the terminally ill was not possible in Springfield, so I turned my attention to the aged.

Project LIFE

I met Mrs. McAdams while trying to conduct a survey. We formed a friendship and then we lost contact. Soon after I joined the Project LIFE staff, Mrs. McAdams, in her search for someone to aid her, called after hearing our radio announcement. I recognized her voice and our friendship has continued.

It does give a sense of satisfaction because you can give a direct service.

Project LIFE is an administrative body, as such, it is hard to give a direct service to individuals. I think it is very rewarding if you can work on a one-to-one basis with people.

It helps both parties involved.

[Applause.]

Senator PERCY. I can see that you can help provide some leadership and inspire others to do just as you have done.

I certainly commend you on behalf of the staff, and the members of this Senate committee.

Mr. Chapin, you indicated to me in your statement that the biggest complaint among healthy senior citizens is high taxes.

The President in his tax reform package has proposed a formula for tax credits, up to $500 for middle and low income persons over 65.

The credit would be available to renters as well as homeowners. Credit would be provided in cash for persons making no tax return. This is opposed by George Meany, I understand.

Have you a position on it? Do you feel that it is in the right direction, or do you think we ought to go in some other direction?

Mr. CHAPIN. I think it is in the right direction. There are two things. One is the senior citizen that pays taxes, you can reduce his tax bill, if he pays income taxes, he can get a credit on it, but suppose he does not pay either, he is the worse off of all, and he needs a tax refund.

Senator PERCY. You did mention your testimony before the house committee in Illinois on the proposed sales tax reduction on food and drugs, and that, during the course of that testimony, you discussed a little bit the dietary habits of the elderly, which you did not expand on here.

Would you care to expand any further, or was it primarily the subject of elderly people eating dogfood that you spoke of?

Mr. CHAPIN. Senator, in the position that we are in, when a person complains as a senior citizen, and I happen to be on the joint committee for legislation for most of the Illinois senior citizens organizations, so I would say we get a lot of complaints, we do not have to go out and hunt people to find out what is wrong.

They find us, they want new bills passed, and most of them want a bill to reduce taxation some place along the line.

We could also get the idea they want a bill to reduce taxes so they can improve their food buying habits, and particularly paying for medicine.

If a bill is already in the house or senate, and it covers that, okay, but there are people constantly writing in, wanting new bills passed, to cover certain problems they have, and they seem to go back to nutrition, medicine, and so on, which of course means they want to spend as efficiently as possible.

Senator PERCY. This is my last question, and any of you may comment on it.

This again deals with food, really good nourishing food, which I look upon as the best medicine. We have had eloquent testimony that nutrition, adequate nutrition would prevent the necessity for medical attention in many, many cases.

I believe that food is something else besides just nourishment for the body. It is a little nourishment for the soul, you might say.

I know we at our family home always look forward to breakfast in the morning. We do not let anything else interfere with breakfast

around the table and a leisurely breakfast so we can talk together, and we look forward to our dinners.

I think the dining room table is what has bound the American family together for years, and I think the worst thing that could happen is these TV dinners, where you sit down with the TV dinner on the lap, and you look at the tube, and you haven't had a chance to talk. I think they have destroyed a lot of the community feeling inside the family.

[Applause.]

Nutrition Program for the Elderly

I fought very hard for the nutrition program for the elderly. I almost lost on the floor of the Senate; we had 2 days to go before my experimental program was to die and they said, "Well, it is an experiment; it has been proven out; let's let it die."

We did not let it die. We let it grow from a $2 million program to a $100 million program, and to convince the White House, I took Dr. Flemming out, and had him call, as I have for years, on feeding programs. I would like to tell you about a woman, Mrs. Green, whom I had never met. Here were 30 people from the community in a church basement for a hot meal. Twenty-five cents is all they had to pay.

They had to pay something, but they paid 25 cents for the meal that cost $1.76, I think. For Dr. Flemming's benefit I said, "Mrs. Green, what does this meal mean to you?"

She said, "Senator Percy, this is the difference between life and death to me."

I said, "You do not look like you are starving to me."

She said, "I do not mean nourishment just for the stomach. It is the soul too." She said, "Last week, I did not feel well. I live up on a higher floor in a little room in the back of this rooming house. I have a little hot grill up there. I could fix something, but I just did not feel like coming down here for lunch, so I stayed up in my room.

"About 12:30 I heard the shuffle of feet outside, and my door burst open, and one of the people from the center said, 'Jessie, what are you doing in that bed? You get up and get dressed.'

"I said, 'I don't feel well.' They said, 'You are going to feel worse if you stay up here alone.' So they helped me dress, and I went down. You know after about 3 o'clock, and I had my meal and was playing cards, I forgot how badly I felt, just because of the fact that someone cared and because of this feeding program where I dress up, I come down here, I see my friends. It has put me back into society again, and to think I have been on a shelf, neglected and forgotten, for years before this program came to our community."

Do you agree that this is a tremendous opportunity? When we spend hundreds of millions of dollars for farmers who are subsidized, and when we spend billions of dollars all over the country to take acreage out of production and pay farmers for not producing food do you agree that $100 million is a pittance compared to the $4.5 billion in farm subsidy programs to control production and keep

production down? Don't you think $100 million is one of the best investments we could make?

[Applause.]

There is no disagreement, I gather.

I am happy to say, those programs are going to be funded. It will be set up in Springfield, and every community in this State will have a chance to have such a program.

Mr. Mueller, I have just a couple of questions for you.

Nationally, about 42 percent of all persons 65 or over are licensed to drive.

The other 58 percent often have very limited options. They can ride with their children, providing their children live nearby, or they can pay a neighbor to take them to the doctor or store, or they can walk, or they can do without.

Unfortunately far too many live under a form of house arrest, you would almost say, cut off from medical services, their friends and families.

40 Percent Experience Transportation Problems

In your judgment, how many of the elderly in your county experience transportation problems?

Mr. Mueller. I would say at least 40 percent. It figures out at least 40 percent of those over 65.

Senator Percy. Do you think I was right when I led the fight to defeat the SST which would have cost the Federal Government some $20 billion in order to get some businessmen to London at 4 in the morning instead of 6 in the morning? I fought that and defeated it, so we could get more money for mass transportation. Do you think that that is a correct priority?

Mr. Mueller. Absolutely.

Senator Percy. Is it true in your judgment that the harshest penalty paid by those living on fixed income, particularly the elderly, is inflation?

Mr. Mueller. That is right.

Senator Percy. Is it true that inflation taxes their whole life savings, and makes meaningless their life savings?

Mr. Mueller. In fact, it is depleting the savings the people had, that they felt they could live on normally, and there are a number of them that cannot live normally, and would have been on what they had saved if it had not been eaten up.

Senator Percy. Just look at a person who, as recently as January 1968, retired with just enough income to live on, and look at what has happened to his costs.

Food has gone up 33½ percent, property taxes 48½ percent, medical care overall 32.2 percent. If he has to go into a hospital, and he has a semiprivate room, costs have gone up 70.5 percent.

How does that person get by?

Mr. Mueller. I don't know.

Senator Percy. What if they retired in the early 1960's or 1950's and did not expect to live to be 90, but are still living now? How do they get by?

Mr. MUELLER. I don't know. I know I get by with the insurance I carry which costs quite a bit of money each month, and with the income I have, I don't know how many of these people with $100, or $125, or $80 a month, I do not know how they get by.

I have contact with a number of those people, and I just really do not know how they survive.

Senator PERCY. From the standpoint of the allocation of manpower in this country, when we need something, we get it.

When Sputnik went up, we started spending money hand over fist, billions of dollars to train people in mathematics, physics, chemistry, to catch up with the Russians.

That dirty word, "Federal assistance for education," was suddenly a way to fight communism, not educate little children, and there was no objection after Sputnik. We just moved right ahead. Now we find schoolteachers are in excess. We trained them, and today we have 70,000 excess schoolteachers.

MEDICAL CARE PERSONNEL SHORTAGES

We have 50,000 excess engineers, scientists, and technicians, and now with the space lab in trouble, we may have a few more in surplus, and yet we are 50,000 doctors short, 150,000 nurses short, 22,000 dentists short.

What can be done to convince people to go into medical care, and to go into those professions where we desperately need them and to not go into professions where they are not needed?

Mr. MUELLER. The only thing I know of would be to subsidize the college for these medical students.

That would be the only thing I know of that would increase the amount.

Senator PERCY. There are not many parents that can afford to pay $40,000 or $50,000 for the education of a child to go into medicine.

Mr. MUELLER. That is correct.

Senator PERCY. So there must be strong support for a man or woman who goes into the medical field.

Mr. MUELLER. That is right.

Senator PERCY. Do you have difficulty in getting medical personnel to go into Scott County?

Mr. MUELLER. We do. It is very difficult.

Senator PERCY. What about a scholarship program that would pay virtually all of the medical educational costs for someone who could not afford it, if he would promise for 6 or 7 years to practice in a rural community that needs a doctor, or in the inner city area that needs doctors, rather than going into the suburbs where they want to practice, where there is a rich practice and a nice living?

Mr. MUELLER. I think that is a good proposition. The one man that we had there, he practiced about 7 years, and then he moved about 20 miles away where he could be close to the hospital, and he did not have to make the house calls at night, and he made more that way; but you take a doctor in our community, that is good between $40,000 and $60,000 a year if he would stay there and practice.

Senator PERCY. I have a suggestion I picked up when I was out in California dedicating a neighborhood health center in a Spanish-speaking community down below San Francisco. I substituted for Senator Robert Kennedy who had been assassinated the week before, and he was to be there, and I flew out to do this in his place. He had told me that they had great difficulty getting doctors to practice down there.

All wanted to practice in San Francisco, but not in the Spanish-speaking community. In this community, 70 or 80 miles south of San Francisco, a very enterprising Federal judge and a U.S. prosecutor who was prosecuting two doctors for income tax evasion gave them a choice, a year in the Federal prison, or 3 years practicing down there. And they went to this community. We are now going to have a new Federal judge coming to Springfield, as soon as he is confirmed by the Senate. I suggested Arlington Woods' name to the President of the United States, and I am delighted he has nominated him now to the Senate. And Mr. McKay has been nominated for U.S. attorney. I have suggested to these two men that they might seek this as a remedy.

[Applause.]

I would say from what I have seen of Scott County, it is a lot better than a Federal prison. It is a nice place to live, a lovely place to practice.

If you have facilities, and there is a great need, I would hope you would not have to resort to measures like this.

I believe doctors ought to take their practice where they are needed. If they did, more would practice in rural communities, and more would practice in the inner city where they are so desperately needed, and particularly in downstate Illinois where life is really worth living, and much more pleasant than in most of our cities.

I want to thank this panel very much indeed. You have been wonderful, and I am grateful for your being here. I express the appreciation of the U.S. Senate and my colleagues in the Senate for the life-long service you have given to the cause of the senior citizen.

Thank you.

Mr. MUELLER. Thank you.

Senator PERCY. I wonder if we might have Miss Edith Heide and Mr. Joel Edelman come up together.

Our next witnesses are Miss Edith Heide, registered nurse, assistant chief, division of nursing, Department of Public Health, Springfield; and Mr. Joel Edelman, acting director, Department of Public Aid, State of Illinois.

Miss Heide and Mr. Edelman, we are very pleased to have you here.

Miss Heide, you can go first.

STATEMENT OF EDITH HEIDE, R.N., ASSISTANT CHIEF, DIVISION OF NURSING, DEPARTMENT OF PUBLIC HEALTH, SPRINGFIELD, ILL.

Miss HEIDE. Senator Percy, I am honored to be asked here to testify for the senior citizens and the Illinois Department of Public Health.

One of the major barriers to health care for older Americans is that, under our present Medicare system, there are no payment mechanisms to provide for prevention or early detection of disease, for long-term rehabilitation after the acute stage of an illness is over, or for other home services.

Part A of Medicare pays primarily for hospital care, long-term institutional care, and some home visits after the patient has been hospitalized for at least 3 days.

Only about 5 percent of our older citizens need to be in long-term care institutions and only occasionally do they need hospitalization. The majority of elderly Americans are not able to obtain extensive health care at home, or at ambulatory physician or nonphysician directed clinics where they can get the services they need to keep them well.

The present system is based primarily on the needs of the acutely ill, but what we also need is a program to provide for the needs of those who have not been hospitalized.

In other words, the emphasis should be on "wellness," not "sickness."

Under part B of Medicare, there is an allowance for home visits but it is a very short term benefit compared to the realistic needs of the elderly.

There is no provision for long-term followup to keep the patient on the road to recovery, or to maintain him at the level he has reached.

As a result, the person may have regressed to the point of needing more extensive medical and nursing care before he can get more service paid for by Medicare.

"Skilled Nursing" Care

Another barrier to the elderly person who needs home health care is the Medicare requirement that home visits must be classified as "skilled nursing" care.

In many instances, "skilled nursing" care is not available, or is more than the patient requires.

Many home health agencies have developed to provide care for the elderly only as long as Medicare payments can be made.

Once the person no longer needs skilled nursing care or other services such as physical therapy or speech therapy, the agency will not continue service unless the patient can pay his own bills even if the need still exists.

The elderly person who is not entitled to Medicare coverage does not receive assistance from these agencies unless he can pay.

This practice will continue until the taxpayers are willing to support a local official health department. These departments can provide the needed long-term teaching or professional or allied professonal services necessary to keep the patient "well" or from regressing as rapidly as he would without the assistance.

There are many areas without a home health service. In Illinois, there are 82 certified home health agencies, and about half of these are clustered in the Chicago metropolitan area.

Forty of Illinois' 102 counties do not have countywide health service at this time. Under the present system, people in these counties cannot receive care at home no matter how badly they may need it or how payment is to be made.

This situation is due primarily to a lack of concern on the part of the public until it becomes a personal problem. There is also a lack of concern on the part of physicians to refer people for home care.

In rural areas, it is difficult to obtain financial support for a home health agency when the requirements are as described in this paper or when the agency must depend solely on Medicare payments for its existence.

We must develop some method of making payments for health services to elderly persons in their homes as there are many who could stay at home if this were provided.

Experience has shown that most persons do not require institutional care and are much happier or healthier at home.

They stay more mentally alert; they have their families and friends around them; and are generally more satisfied at home no matter how poor that home may be.

Paying for certain types of services in the home—such as shopping, cooking, housecleaning, laundry, or friendly visiting—would not only fulfill the needs of a large percentage of the elderly, but would be much less expensive than paying to have that same person hospitalized or in a long-term care institution.

Public Welfare Recipients

The department of public aid has provisions to pay for homemaker service for elderly welfare recipients, but the nonwelfare elderly cannot obtain this service.

If the elderly persons are both institutionalized and on public welfare they can get medical visits, nursing care and drugs paid for, but they cannot get this if at home even when on public assistance.

Our present system is forcing many older Americans either to become institutionalized and/or to join the ranks of public welfare recipients.

Another point I would like to discuss is that there is no provision whatsoever to provide extended services for those elderly persons who are disabled, who are amputees, or who suffer from arthritis, paralysis, multiple sclerosis, Parkinson's disease, general debilitation or other nonacute illnesses.

Under our present system too many elderly Americans are denied health care benefits because they are not victims of the right illness.

For example, there is no service available to those older Americans who suffer from arthritis, a leading crippler.

There is no payment for care, for rehabilitation, or for any type of service that will keep the arthritic patient on his feet.

As a result, once an arthritic has gone to bed for any length of time, the joints will ankolsis, and he will probably stay there the rest of his life becoming more deformed.

It is imperative that a mechanism be developed to provide services for elderly patients after the acute illness through the convalescent and maintenance stage.

There is, at the present time, payment for home visits following an acute illness or when skilled care is needed, but there is no provision for long-term care followup to maintain the patient or keep him well.

Added to all these problems are the complexities of health problems related to aging. The elderly do not come with one disease as they have had time to acquire many diseases.

This means that many older persons are faced with the confusing business of following diets which may conflict with one another and taking as many as 12 different medications a day at the proper time or following other complicated medical regimes.

For example, an elderly patient who must take medication for cardiovascular diseases, may develop diabetes and suffer from all the ramifications of that disease.

This means that the patient must not only take the heart medication properly and probably follow a low-salt diet, but which must be nutritionally sound, now has the added problem of following the diabetic diet and take its medication .

Obviously, these people need assistance with medication and diet, through continued nursing assessment visits, but this type of service is not now available or paid for by Medicare.

Another problem for the elderly is the deductible aspect under part B of Medicare. Many do not have a mechanism for making this payment. Also, the physician's charges may be more than allowed by Medicare and someone has to pay the difference.

Many physicians will not provide care to people on Medicare or public welfare because of the fee schedule and/or the paperwork involved.

It is my sincere hope that through the hearings of this subcommittee there will be the development of mechanisms that will eliminate the voids in our present system, two of which are the lack of preventive care to keep problems from developing and the lack of long-term care at home that will maintain elderly persons.

I also hope that, as a result of these hearings, our elderly citizens will all be able to obtain the kind of health care services they so desperately require.

Thank you.

Senator PERCY. Thank you very much.

Mr. Edelman, we would be happy to hear your testimony now.

STATEMENT OF JOEL EDELMAN, ACTING DIRECTOR, DEPARTMENT OF PUBLIC AID, STATE OF ILLINOIS

Mr. EDELMAN. Thank you, Senator.

The last time we met, you were on a mission of mercy visiting the victims of the Illinois Central tragic train wreck, and the sympathy and the understanding you displayed on that occasion convinces me as well as today's hearing of your commitment to people, and to their problems and to resolving their needs.

[Applause.]

Senator PERCY. I might say I was never more reaffirmed in my faith in the human race than that day when we had that tragic accident.

I went in to donate blood and stood in a line that was two blocks long with people waiting to donate blood to help their fellow man, and I thought that was a wonderful illustration of what people will do and Americans will do in any crisis or emergency.

Thank you. Go ahead.

Mr. EDELMAN. Speaking as a State official and, specifically, as the director of the Illinois Department of Public Aid, I want to elaborate on four areas of concern raised by Governor Walker which are major barriers to health care for senior citizens.

First, a shortage of health care personnel. The continued shortage of personnel in Illinois—and particularly the shortage of physicians—presents a problem which cannot be directly resolved by any of the State or Federal agencies.

The State has made concerted efforts during the past 2 years, through offering various monetary and professional incentives, to encourage new doctors graduating from Illinois medical schools to practice within the State.

I might add in light of your comments, that you might consider some kind of effort to help the physician who wants to practice in a rural area to secure the intellectual stimulation he would seek at a major medical center in a large city. I think the problems of recruiting doctors for rural areas were heightened by the loss of funds for postgraduate education under the regional medical program.

In addition to a doctor shortage, there has been—and continues to be—a reluctance on the part of some physicians to serve patients whose bills are to be paid through the State's Medicaid program.

The Department of Public Aid is attempting, with the help of its medical advisory committee, to reverse this trend.

In 1967, the number of doctors accepting Medicaid patients numbered 3,000. During the current year the number is reaching 11,000. The problem is still a real one but is improving.

SHORTAGE OF FACILITIES

In addition to a shortage of medical personnel, a second siginficant problem area is the shortage of facilities.

To compound an already difficult situation, proposed new Federal regulations for intermediate care facility services set requirements for nursing homes which could eliminate 20,000 nursing home beds for public aid patients in Illinois.

At the same time these standards for nursing homes are being increased, Public Law 92–603 prevents the State from increasing payments to nursing homes by more than 5 percent of the rate being paid the preceding year.

Illinois agencies, including the Department of Public Aid, support Federal regulations which insure continuity of care for aged and disabled nursing home patients and support regulations which insure safety and health standards, but we have vigorously protested changes which we feel are unnecessary and increase cost without benefit to our patients.

A third problem area surrounds the Federal Medicare program and the State's Medicaid program.

Transportation Problems

Let us look at Medicare—specifically, coverage of transportation to the source of medical care.

We in the State continue to find denial of payments or reductions in payments for transportation under the Medicare system, and we have been unable to determine any consistent pattern to Medicare's refusal to pay total or partial charges, such as for such things as ambulance services.

This inconsistency can, of course, have a devastating financial effect on the individual concerned, but it also creates problems with our department's implementation of Medicaid.

Until we know what charges Medicare will cover, we are unable to determine claims paid by the State under Medicaid, because these two programs work hand in hand.

This double delay in payment has understandably caused many ambulance companies to flatly refuse to accept Medicare or Medicaid patients, or has caused the companies to require patients to pay full charges in advance for services, thus leaving the patient to negotiate with Medicare and take any financial loss resulting from Medicare's denial to pay.

It should be emphasized here that Medicare only pays for ambulance service. In Medicaid we have extended our service to pay for cabs and to reimburse neighbors who are willing to transport patients to and from hospitals and doctors' offices.

Another problem stems from current requests for increased emphasis on service provided in the home by health agencies.

While this is an area which certainly needs expansion, the same problems which I have just mentioned seem to be apparent.

Inconsistencies in policy interpretation and in payment regulations have resulted in problems for home health agencies, and a large number of such agencies in Illinois have been forced to close due to financial problems related to denials of benefits or payments.

Until Medicare officials clarify their regulations, they cannot expect a favorable response to their request for increased home health agency services.

It seems to me if you want to provide incentives, that you have to be willing to provide financial reimbursement.

Aid to the Aged, Blind, and Disabled

Finally, let me briefly mention the proposed Federal takeover of Aid to the Aged, Blind, and Disabled (AABD), currently scheduled to take effect next January 1.

The new regulations are unclear on matters surrounding Medicare and Medicaid coverage for persons who will require assistance through both programs.

I think Mrs. McAdams is a good example of one such individual who stands to be severely disadvantaged in the course of a Federal conversion.

We do not know, for example, if Federal financial participation will be available to help cover the cost of supplemental medical

insurance premiums if the State elects to make all Federal AABD cases eligible for medical assistance-no grant.

Will recipients be required to pay a monthly premium?

If so, will the amount of the premium so reduce the recipient's income that he would be eligible for supplementation by the State, if the State decides to supplement Federal payments?

Also, the State has not previously elected to pay the Medicare premiums for MA-NG cases. If this policy is not changed, the recipient could be required to pay the part B premium plus an additional State premium for MA-NG recipients.

Unless the Federal regulations are clarified, we in Illinois do not know exactly what our role will be.

That is the individual who is not on a cash assistance program, but who needs support or subsidy for meeting medical and hospital bills.

In addition to this dilemma, public law mandates payment of a monthly premium under the Medicaid program in addition to this part B payment of premium under the Medicare program, so now we have two possibilities of taxing the individual, or the State by way of part B under Medicare, and by way of mandated premiums under Public Law 96–203.

This appears to be a back-door way to shift the burden of medical costs, back upon the individual citizen, and certainly upon the taxpayer of the State.

It may also be the payment of these premiums may reduce the real income to the senior citizen that he or she would be eligible for supplementation by the State as may be provided under the program.

This is another way of taking money out of one pocket, and compelling us through taxpaying revenues to add some at least to keep the individual citizen somewhat in balance, keeping in mind of course always that the individuals involved are subsisting on meager incomes.

While this is a problem for our department and other State agencies, the ultimate effect falls on the recipient—the person who is aged, blind, or disabled and already is attempting to subsist on a meager income.

Most of the concerns which I have mentioned were listed as problem areas in health fields by the more than 30,000 Illinois citizens who helped form the State's recommendations to the 1971 White House Conference on Aging.

"More Confusing and More Uncertain" Programs

Unfortunately, these problems have not been ameliorated by passage of new Federal regulations and the situation, if not the same, has become more confusing and more uncertain to the recipient and to State agencies attempting to provide services.

Senator Percy. Thank you very much.

We have talked a lot about the costs, the problems of transportation which are very real problems for the aging.

I wonder about the telephone. It is looked upon still as a luxury. Yet I wonder whether there are not circumstances where we could recognize part of telephone costs as a medical cost. If a doctor certi-

fies the fact that keeping in touch by telephone would be essential and they looked upon it not as a luxury, but as a life link between themselves and a doctor, it might at least be within the power of the State to relieve the elderly person of paying a very high tax on their telephone. The doctor might be able to give advice on a telephone quickly and readily and remedy a situation that way rather than by the necessity of a personal visit. I have never heard any proposal about that, but I have constantly heard complaints about the fact we do not recognize the telephone as sheer necessity for the elderly person.

Mr. EDELMAN. It might be in part because on Wednesday we cannot find a doctor near the telephone. But seriously, I think your suggestion is an excellent one, I would add to it, if I may, the thought of those doctors practicing, certainly in clinics, we ought to make greater use of the registered nurses in the system, so it might not require the doctors to interrupt their daily work, that in fact the senior citizen could call the office, the problem could be handled by a nurse, if they were properly trained and oriented to this system, and if she feels the doctor's attention is necessary, she will then call the doctor into the telephone conversation, so I think we have to do a little education with the senior citizen population, understand this is not a brush off, but that the nurses are properly trained, and that they might be able to answer many of these questions.

Senator PERCY. As you know, this month the President signed the 1973 Older Americans Act Amendments.

KEY PROVISIONS ENACTED INTO LAW

One of the key provisions in the bill I have been fighting for is a proposal to establish an older worker community service jobs program for people 55 years and above. I am pleased this provision was incorporated.

These individuals under this program now are authorized to provide a wide range of community services, including services of home health aides, homemakers, and others.

Do you feel that these elderly semiprofessionals could be helpful in providing assistance to enable professionals to direct their attention to more pressing health matters, freeing them from some of their routine tasks?

Miss HEIDE. I very definitely do. This is a real need, as I stated, and the older person who would like to feel needed, can go to someone else who needs that help.

We need their expertise, we need it so that they could do the cooking, sit down and eat the meal in the home with the person.

We could have them help with some light housework, and we do not want to ignore the gentleman in this.

We need their expertise in repair work, in doing the things around the home, that can keep this person at home, and keep the house in good order, repair the furnace, put a nail in a board that is coming loose, cut the grass, do a few things like this that will let this person stay at home.

He could be used to supplement that person's income.

Senator PERCY. Mr. Edelman, you indicated in your statement, with respect to Federal regulations on nursing homes, we have opposed

changes which we feel are unnecessary, and merely cost increasing.

Obviously you are not talking about the kinds of changes that I have fought for since the tragic fire that we had here that took lives—changes providing for adequate lighting at night, and emergency lighting standby equipment, and access and egress, and so forth.

What are the types of things you are talking about which you feel are not necessary, and which just simply add unnecessary costs?

Mr. EDELMAN. Primarily, Senator, I was referring to the requirement there be one level of intermediate care.

The skilled nursing care, and then one level of intermediate care.

In Illinois, we have licensed on provisional basis homes that would not immediately qualify under the one level of intermediate care referred to in the regulations.

We would lose a substantial number of beds under the concept of sheltered care, these are facilities which provide what we call supervised care to individuals who are ambulatory, but who do need some supervision.

We think this is a justified form of care that should be available to senior citizens, and that we think that the regulations as are adopted, or at least issued with a view in mind of cutting costs rather than the view in mind of the needs of the individuals, we think of what may happen as a consequence is that a lot of people will be moved into facilities which afford greater services than they need at greater cost, and it may have the reverse effect of what is intended.

Senator PERCY. Miss Heide, as you know, if we could shave off one day from the Medicare national hospital average, we could save about $400 million.

You have been, as I have been, a proponent of developing alternatives to institutionalization, because institutionalization is the most expensive, and sometimes the most inhumane method of care.

ALTERNATIVES TO INSTITUTIONALIZATION

Could you give us any further suggestions as to what we could do to develop a comprehensive policy to provide effective and meaningful alternatives to institutionalization?

Miss HEIDE. Again, of course, there has to be some financial support from some place, whether it is the Federal Government, or the local.

We need some community-based services, that will bring in total persons, will include them mentally, physically, vocationally, the recreation aspects, all of that they will need.

We have talked here, it has been mentioned about the nurse, we talk now about we can have nurse-operated clinics, where the nurse is the one who sees the person and helps them through their things they need without the physician.

She could do much of the work, and then refer to the physician who may be that 20 miles down the road at Jacksonville from Scott County.

The physician could come and visit once a week into this clinic building that is there.

The nurse could handle the balance of it with ancillary help.

Senator PERCY. Mr. Edelman, because alternatives to institutionalization have been a main theme at today's hearing, would you care to comment?

Mr. EDELMAN. I have not seen the health maintenance organization's legislation in the form that it is, but it seems to me that if we could encourage the development of these prepaid group practice systems, and put into the system some additional incentives, some additional premium for taking into those programs senior citizens who admittedly represent a higher risk of health care costs, to the provider, if we could give the provider incentive by acknowledging this higher risk, we could get more senior citizens into those health maintenance organizations.

If we do not take a positive move into this area, my fear is that the HMO's as they develop, will exclude the senior citizen, because they will be the high risk patient.

Senator PERCY. One or two more questions, but in the meantime, could Mr. Robert Ahrens and Mr. Phillip M. Goff please come to the platform.

Mr. Edelman, our health care for older Americans is geared to crisis treatment.

If we devoted more attention to prevention than we do now, we might not have to structure our health care system in this fashion.

Would you care to comment on this goal, and some of the things we can do to achieve this goal?

Mr. EDELMAN. Well, I think I would pick up on your suggestion earlier, Senator, of involving young people.

GERIATRIC CLINICS

I had an experience with great emphasis on specialty care, so that the senior citizen, if he had a heart problem, would be channeled to the heart clinic, if he had a problem of diabetes, he might be channeled to the diabetic clinic, and very often this individual had multiple problems, he would have to run from one clinic to the next.

There was no geriatric medicine practiced in that clinic.

The medical students who were in attendance at that hospital, took an interest of taking care of senior citizens, and they formed an evening geriatric clinic.

These men were not experienced in geriatric medicine, but they were motivated in the way those students you talked about earlier were motivated, they had rapport with the elderly citizen.

I think if we could encourage the development of geriatric clinics so the entire problem could be addressed, we would make some progress.

Senator PERCY. Finally, from both of you, I think a yes or no is all we need. Do you think Medicare patients should be required to be hospitalized for 3 days in order to be eligible for nursing home benefits?

Mr. EDELMAN. No.

Senator PERCY. A double no on that negative note.

[Applause.]

Senator PERCY. I said on that negative note, but it looks like a positive note.

I thank you for being with us. You have made a very valuable contribution.

Mr. EDELMAN. Thank you.

Senator PERCY. We appear to be reasonably on schedule, and we will be adjourning in 15 minutes. But now we are very pleased to have with us Mr. Robert Ahrens who is the director from the Mayor's Office for Senior Citizens in Chicago. He is accompanied by Mr. Phillip M. Goff, president, Flannery Clinic Council, Flannery Apartments for the Elderly, Chicago.

I have had the pleasure of visiting the Flannery apartments on a number of occasions, and we welcome both of you, and we are very happy to have a statement by you.

STATEMENT OF ROBERT AHRENS, DIRECTOR, MAYOR'S OFFICE FOR SENIOR CITIZENS, CHICAGO, ILL., ACCOMPANIED BY PHILLIP H. GOFF, PRESIDENT, FLANNERY CLINIC COUNCIL, FLANNERY APARTMENTS FOR THE ELDERLY, CHICAGO, ILL.

Mr. AHRENS. Thank you, Senator.

Mr. Chairman, ladies and gentlemen, thank you for the opportunity to talk with you briefly today about some of the health problems of our older people.

It is a great pleasure for me to appear again before this committee, and I would be remiss if I did not express my appreciation for its work, and my respect for the staff that serves it—and all of us—so admirably.

We prize them as colleagues and fellow professionals in the field of aging—as we do the members of the committee—and allies in our efforts to achieve a better life for America's senior citizens.

One of the most serious problems confronting the elderly today is the unnecessary institutionalization of our aged.

The increasing percentages of older people in our society and the proportionate increase in persons with chronic illnesses have resulted in a growing need for examining and improving our methods of delivering effective health services.

No adequate resources exist to meet the needs of the more than 80 percent of the elderly who have one or more chronic health conditions.

Our health care system, and this includes, of course, Medicare and Medicaid, is oriented to the acute illness.

The elderly are not a homogeneous group. Their needs are very complex in all aspects of their lives, and health care is no exception.

Provision must be made for continuity of care from preventive to rehabilitative programs.

For many elderly persons, health care is available only at an impersonal clinic where staff may even be unsympathetic to the special needs of the elderly.

Health care more often than not is a series of uncoordinated services, and an individual may be receiving medication from several

physicians at the same time, each in ignorance of what another is prescribing.

Supportive Services Needed

Many elderly, as has been said so often here, could remain in their homes, where they feel most comfortable and happy, if only supportive services were available when needed.

Our nation must give consideration to allocation of sufficient resources to develop a full range of supportive services to maintain the individual in independent living for as long as it is wise and possible to do so.

In recent years we have seen the development of the neighborhood health center which has considerable potential to provide comprehensive health care to its community.

Because the special needs of elderly persons are frequently overlooked or assigned low priority by most service systems, we recommend that the needs of the elderly be made an object of special interest and effort by the neighborhood health center.

In our judgment an optimal program of such a center would include the following:

(1) A staff position of planner and coordinator of services for the elderly, in addition to the employment of at least one full-time physician specializing in geriatrics.

(2) A full range of outpatient health services including medical, psychiatric, dental, opthalmic, otologic, and podiatric.

(3) A full range of home health services including medical, nursing, personal care, physical therapy, and occupational therapy.

(4) Referral relationships with hospitals for inpatient care.

(5) Referral relationships with facilities for long-term care.

(6) Specialists in service at the consumer level for individual elderly, who would also be assigned to perform outreach and follow-up duties.

(7) Regular in-service training for all staff on the aging process and problems of the elderly.

(8) A policy of preventive care by providing screening and diagnostic tests as well as periodic physical examinations.

(9) A program of maintenance care for chronic illness, providing medication when necessary.

(10) A social service department providing linkage to supportive services such as casework, homemaker/homemaking services, suitable transportation, home-delivered meals, companion-sitter service, friendly visitors, and telephone reassurance.

(11) A health education service to enable elderly persons to conserve their health as well as to understand and cope with their illnesses; and

(12) A system of data collection coordinated with comprehensive data gathering related to elderly persons which includes needs, services offered to meet needs and extent and uses of services.

"Senior Central" Project

In 1972, the Mayor's Office for Senior Citizens in Chicago undertook a 3-year research and demonstration project under title IV of the Older Americans Act of 1965, as amended.

Called Senior Central, the project is a planning and coordinating process, more than a project, addressed to the delivery of services to the elderly.

The major objectives of Senior Central are: (1) To develop an ongoing planning and service structure whereby public and private agencies may work cooperatively to resolve the unmet needs of the elderly; (2) to provide access to a continuum of coordinated services to every older person in the city, especially those with low incomes, the isolated, and those with other deficits such as reduced mobility and emotional problems; (3) to encourage continued independence of older persons by providing supportive services when necessary to delay, reverse or avoid unnecessary institutionalization; (4) to systematize data gathering to facilitate continuing evaluation, planning and program revisions; and (5) to develop at the State level adult social services under title XVI of the Social Security Act.

The city is sharing the cost of this with the Federal Government.

At the present time, Senior Central has two operational field sites established in the community, and a mobile van which provides neighborhood coverage of Chicago's 76 community areas.

Two additional sites will open shortly, to complete the field headquarters for the four service areas into which the total city has been divided.

Last year through this grant a needs assessment survey representative of Chicago's 517,000 people age 60 and over was completed by our office, to determine their felt needs and to provide a baseline from which to measure and evaluate the effectiveness of services to the elderly, and the methods of delivering them.

The survey has strengthened our capacity to encourage and develop services based on research, as well as to plan, monitor, and evaluate their effectiveness.

Based on the needs expressed by the elderly, we have concluded diverse and multiple purchase of service agreements with service providers from the private sector, as a supplement to publicly supported services.

These services, to which an initial $500,000 has already been committed, include: (1) Home help; (2) income review; (3) emergency shelter; (4) door-to-door transportation; (5) counseling and placement in housing; and (6) audiological screening.

The home-help service which is now available citywide, as part of our research and demonstration project, includes housekeeping, light repair work, shopping and some meal preparation.

We have entered into contractual agreements with three private agencies to develop and provide this home help and have limited the average amount of service per client to no more than four units per week.

We hope to develop information on the cost-benefits, cost-effectiveness of these services as well as new knowledge in the experimental area of fixed unit costs for social services.

But most important of all, the senior citizen is enabled to maintain greater independence through the provision of home-help services which most of them could not otherwise afford.

Home help should be included under the in-home services provided through Medicare.

Inadequate Nutrition

Inadequate nutrition is a serious health problem for older people. You have heard all of the reasons why they do not get good nutrition.

Many elderly persons do not eat adequately because they cannot afford to do so, while others, who are economically better off, fail to eat because they lack the skills to select and prepare nourishing and well-balanced meals, have limited mobility which may impair their capacity to shop and prepare meals for themselves, or simply lack the incentive necessary to cook and eat a meal alone.

In 1968, the Mayor's Office for Senior Citizens, in cooperation with the Administration on Aging of the U.S. Department of Health, Education, and Welfare, began a research and demonstration program in nutrition and nutrition education for the elderly.

Our friend, Mr. Goff, was also in Washington with me to help you keep those programs alive a few years ago.

We have been ready for sometime to act on title VII when the money comes, because we want to expand the program.

In 1972 the nutrition program was joined with the Senior Central project as a combined social services nutrition program, with the new objective of achieving a model for the area agencies on aging, who will soon administer titles III and VII of the Older Americans Comprehensive Services Amendments of 1973.

Chicago's nutrition program is a food distribution and social support program which services a low-cost, hot meal 1 to 5 days a week at various locations and under diverse sponsorships throughout the city.

The program currently has 33 community dining sites in operation.

Ojectives are: (1) To raise the nutrition level of Chicago's elderly; (2) strengthen and expand existing social and educational services for the elderly; and (3) provide employment and volunteer opportunities for the elderly.

We look to title VII of the Older Americans Act to enable our office to expand our nutrition program so we may serve the elderly in every one of Chicago's 76 neighborhoods (or community areas) as well as to strengthen linkages to the entire health and social delivery system.

I am sorry to say that the ceiling on expenditures under title XVI and other titles of the Social Security Act and the recently announced restrictive regulations for implementation of the XVI adult social services will impede the objectives of our agency to utilize all existing programs in the development of a comprehensive social service delivery system.

The new limitations not only restrict the number of elderly to be served and the types of services to be provided but, perforce, serve also to restrict benefits in effect to current recipients of old age assistance.

In the longrun, to the degree that they hasten the institutionalization of our older people, these restrictions are counterproductive as a measure to reduce costs, and by their failure to recognize the universal aspiration of people to live out their lives with pride, dignity,

and independence, in their own community, they are alien to American ideals and fundamentally mean in spirit.

We look to your continued leadership to help us fashion programs for our older people, worthy of our free society and the men and women who have contributed so much to it.

Thank you for giving me this opportunity. I would like to introduce Mr. Phillip Goff, who is the president of the Flannery Clinic Council at the Flannery Apartments for the Elderly in Chicago. Flannery was also one of the initial sponsors of our nutrition program.

Senator PERCY. Thank you, Mr. Ahrens, very much indeed, and I appreciate your being here. I do express my deep appreciation to Mayor Daley for having you here and for the bipartisan way in which this program was carried out in Chicago.

The 32 feeding centers have had great importance as an experiment, and I will rejoice when we have 78, one in every single neighborhood.

Now, Mr. Goff, you have developed a model, and how far along are you?

What are your hopes and aspirations?

Tell us a little bit about it.

STATEMENT OF PHILLIP M. GOFF, CHICAGO, ILL.

Mr. GOFF. Thank you for the opportunity to speak to you today on behalf of senior citizens, regarding their health care problems.

I have been involved in efforts to deal with those problems since 1948 when I was a delegate from the Order of Railway Conductors to the conference of railway labor executives that drafted one of the first Medicare proposals.

I am presently a gold card honor roll member of the National Council of Senior Citizens, Inc.

Over the past several years my energies have been directed towards the establishment and maintenance of the Flannery Senior Citizens Clinic.

I am presently the president of the Flannery Clinic Council, Inc. a tax exempt, not-for-profit organization which directs and supervises the overall operation of the clinic.

The clinic provides a new and remarkably improved system of medical care for the elderly, at minimal cost.

The success of this unique health care facility in serving the elderly, as well as the financial problems which continue to confront it, indicate the types of changes in public policy that are necessary in order to insure quality health care to all older Americans.

The Flannery Clinic is the first clinic to be established in a Chicago Housing Authority senior citizens housing project.

It attempts to serve the residents of the Flannery Apartments as well as those senior citizens living independently within the local community.

All members of the board of directors of the clinic council are, like myself, residents of the Flannery Apartments.

Flannery is truly a community clinic set up to insure that the persons served have an input in formulating its policies.

Flannery Clinic's services cover all of the aspects of both outpatient and inpatient care.

Arrangements with Northwestern Memorial Hospital for specialty consultation, complete laboratory and X-ray work, and prompt inpatient care have been in effect since January 1971.

Northwestern makes no charge to the patients of the clinic beyond any third party coverage they may have.

Emphasis on Preventive Medicine

Flannery Clinic is unique in its emphasis on preventive medicine which is necessary at all ages, but especially in the older patient.

It recognizes the necessity of making medical care readily accessible so that early recognition of difficulties and convenient follow-up visits can result.

The remarkable convenience of the clinic in the senior citizens' own residence building and the provision of special transportation services to and from Northwestern Memorial Hospital help to eliminate transportation barriers which commonly keep older people from getting the health care they need.

The patients served by the Flannery Clinic, for the most part, do not experience the anxiety so often produced by a depersonalized approach to the provision of health care services such as is found in large university medical school clinics.

The close relationships that have developed between the staff and many of the 3,500 patients they have served over a year have proven to be vital to the maintenance of good health and good spirits.

Most of our patients visit our physician once a month as is consistent with the practice of preventive medicine.

Flannery does not provide free medical services to all patients but it insures that financial problems will not prevent persons from getting the care that they need.

No patient is refused service at our clinic. Many patients at our clinic are unable to meet the deductible provisions of Medicare which require that the person receiving service pay for the first $60 of outpatient care and 20 percent of the charged fee for continuing service.

As a result, Flannery Clinic receives no payment from the Medicare program for the first six visits to the clinic of many of its Medicare patients.

Flannery Clinic has attempted to cover other medical expenses for its patients which are not covered by Medicare, such as prescription drugs.

We failed miserably. It is too costly.

With its goal of rendering patient-oriented and highest quality care as inexpensively as possible, it serves as a prototype of needed change in medical care delivery.

Hospitalization—Half the National Average

The relatively low rate of hospitalization of Flannery patients is one measure of its success. While, nationally, the rate of hospitali-

zation for persons over 65 is 10 percent each year, Flannery Clinic patients are hospitalized at the rate of 5 percent.

It is half of the national average.

Even though it is organized on a tight budget and receiving back-up from other institutions in the community, Flannery Clinic cannot quite sustain itself.

We are in the hole.

At present, funds for the clinic come almost entirely from reimbursements from Medicare and Medicaid.

We know that we could serve more people if we had funds for community outreach work, for transportation to bring persons to and from the facility, and full-time paramedical personnel.

The continuation and development of Flannery and other facilities like it requires changes in the type and extent of public funding of health care programs for senior citizens.

Based on the experience of our comprehensive, community based health care facility, I would like to make the following recommendations:

(1) Seed money for setting up such clinics should be provided by government programs.

(2) Coverage under Medicare must be expanded to include the cost of prescription drugs.

(3) The deductibles for both inpatient and outpatient services should be eliminated.

(4) Funds for transportation to and from clinics must be available.

(5) Other supportive services such as paramedical personnel must receive financial backing from Government grant programs.

(6) The hospital backup provided to the patients of Flannery by Northwestern Hospital is unique yet vital to the success of our clinic.

Government assistance and support for such cooperative arrangements is necesary to guarantee the development of other clinics like ours.

(7) Community education programs dealing with health care, proper diet, and other types of preventive measures need financial support.

In the long run these and other programs which I have recommended will result in increased savings rather than increased cost to the public.

Most important, they will result in much improved health care for older people.

Flannery Clinic has demonstrated the need for preventive medicine and its acceptance by elderly persons.

Medicare must be revised to include support for programs of preventive medicine such as the Flannery Clinic. I submit for the record a fact sheet from the Flannery Clinic.

FACT SHEET

Name: The Flannery Senior Citizens' Clinic, a *community clinic.*

Management: This nonprofit, tax exempt health care facility is managed by the Flannery Clinic Council, Inc. All members of the board of directors are residents of Flannery Apartments.

Location: Flannery Apartments for Senior Citizens (operated by the Chicago Housing Authority), 1507–1531 North Clybourn Avenue, Chicago, Ill. 60610,

312—642-9010. Also serve: Eckhart Park Apartments, 838 North Noble Street; Eckhart Annex Apartments, 847 North Greenview Street.

Purpose: To provide *low cost, high quality, comprehensive* medical services for senior citizens.

Services: All primary care services are provided to the 420 enrolled patients at the clinic site by a full-time LPN, two volunteer RN's, and five physician sessions per week (one staff physician, two volunteers).

Backup services: All necessary specialty and inpatient care is provided by Northwestern Memorial Hospital, Wesley Pavilion.

Important considerations: Consumer Controlled; moving towards fiscal solvency; works effectively with existing resources, that is, Chicago Housing Authority, Cook County Hospital, Medicare, Northwestern Memorial, Wesley Pavilion, Mayor's Office for Senior Citizens; in legal matters Flannery's Clinic Council, Inc., is represented by Mr. Allan I. Becker of the Kirkland and Ellis law firm; address, Prudential Plaza.

Length of operation: Established in December 1969.

Target population: The residents of Flannery Apartments as well as those senior citizens living independently within the local community. Including Eckhart Park and the Eckhart Annex Apartments. Over 60 percent of the residents receive public assistance. The income of the others is from Social Security benefits and/or private pensions. CHA regulations place a $3,000 ceiling on yearly incomes to obtain residency in Chicago Housing Authority buildings. The average age of the resident is 77 years old. Over 80 percent of the patients are black.

Ultimate aim: (1) To develop the Flannery Clinic as a model of primary health care delivery for the aged; (2) to develop and implement a plan for a network of primary clinics to be located in the existing 40 buildings for the CHA senior citizens.

Senator PERCY. Thank you very much indeed.

I have a question for both of you. I have been impressed with what we have done in recent years, in the last decade or two, to provide multipurpose facilities for young people.

Every campus seems to have a union building or some place where young people can get together, and yet if you want to have get-togethers for the aged, you go down to St. Petersburg or some city that caters to the aged, and it is hard to commute down there.

I have tried to get legislation enacted for multipurpose senior assemblies, where people have so much in common, who want to engage in handicrafts, club activities, public affairs, conferences, get-togethers, with a central location for nutrition programs. I am happy to say that the Older Americans Act, which has been put into law now, does provide for these centers.

In your opinion, both of you are experts in this field, do you think these centers should also be used to provide essential health care in addition to all of the other purposes that can be performed?

Mr. GOFF. Absolutely.

[Applause.]

Mr. AHRENS. There ought to be programs of health screening. As you know, we carry these out with the nutrition program at different sites.

NEIGHBORHOOD HEALTH CENTER

I would opt for the neighborhood health center as a very good answer; a community-based thing, with a comprehensive program to serve senior citizens, such as the 12 points in my paper, and also the kind of thing happening at Flannery Clinic.

It should be that older people have a choice. All kinds of community resources can be drawn upon, and I do support also the multi-purpose centers.

I am glad to see that provision of the Older Americans Act, and I hope we will take advantage of it in Chicago. But I want more than just centers; I want a whole city that is congenial to its older people.

Senator PERCY. Very, very good. You have to be able to get around that city, of course, and that brings us back to transportation. As you know, I fought for years to get the CTA to recognize that what is good for the goose is good for the gander, that if young people can travel at reduced fares, so should the older people, and not have them take a means test, just show their Social Security card.

Is the reduced fare for lower income people during the nonrush hours working out well in Chicago and filling a need?

Mr. AHRENS. We are now on a 24-hour, reduced-fare program in Chicago, and it is indeed meeting a need. However, I served as the consultant on transportation to the White House Conference on Aging, at Dr. Flemming's request, and you cannot help but realize after those meetings that we have a transportation crisis in our cities, our rural areas, and our small towns. Chicago was happy to be able to provide the 24-hour reduced fare, but at the same time, you must realize that a reduced fare is no good on a transit line that goes out of business, or on one that cuts services in your block. There must be operating subsidies from the Federal level, State level, and also local level to keep those transit lines functioning well.

Senator PERCY. I will also put in a plug for my bill to require reduced fares on all interstate commerce, trains, busses, planes—again, if they are willing to take standby seating, and the older people who are retired can go at nonrush hour. They do not have to go at 5 o'clock on Friday night. They can go on a seat-available basis.

I do not see why those planes and trains should be empty.

They ought to be filled with people who visit their grandchildren and move about a little bit more.

[Applause.]

Because we have reached adjournment time, I would like first to thank our two distinguished panelists for being here, both for the devotion that you have had in this field and for what you are doing to improve the quality of life for so many of our most valuable citizens. I extend that thanks.

I would also like to thank the staff of the U.S. Senate Special Committee on Aging, our chief counsel, and our minority counsel, and all of the others.

On behalf of this committee of the U.S. Senate, I officially extend our deep gratitude to each and every one of you for doing this noble cause.

With that, the hearing is adjourned.

[Whereupon, the hearing was adjourned at 12:05 p.m.]

APPENDIXES

Appendix 1

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1.—LETTER AND POLICY STATEMENT ON PAYMENT TO HEALTH CARE INSTITUTIONS, FROM WALTER J. McNERNEY, TO SENATOR PERCY, DATED JUNE 1, 1973

BLUE CROSS ASSOCIATION,
Chicago, Ill., June 1, 1973.

Hon. CHARLES H. PERCY,
U.S. Senate,
Washington, D.C.

DEAR SENATOR PERCY: Thank you for your recent invitation to attend the hearing of the U.S. Senate's Subcommittee on Health of the Elderly, which was held in Springfield on May 16.

I regret that I was unable to attend personally, although a member of our staff was present. I would like to take this opportunity to formally submit for the record the Blue Cross Association's views with regard to several of the issues that have been and will continue to be addressed by the committee.

Attached are the Blue Cross Association's policy statement on health maintenance organizations, planning of health facilities and services, and payment to health care institutions, all of which have been adopted by our board of governors. In addition, there is the latest status report of our activities in the development of health maintenance organizations throughout the country.

I hope that these documents will assist the committee in its deliberations.

Sincerely yours,

WALTER J. McNERNEY,
President.

[Enclosure.]

POLICY STATEMENT ON PAYMENT TO HEALTH CARE INSTITUTIONS,[1]

ADOPTED BY BOARD OF GOVERNORS, NOVEMBER 13, 1972

The adoption, by the American Hospital Association in 1969 of the *statement on the financial requirements of health care institutions and services*, as well as the pursuant adoption of the *policy on the implementation of the statement on the financial requirements of health care institutions and services* and the *guidelines for review and approval of rates for health care institutions and services by a State commission*, has raised several public policy issues which have long been a concern of Blue Cross. The debate over national health insurance has undoubtedly sharpened the issues. Three issues fundamental to the financing of health care are addressed below:

—What elements should be considered in calculating rates of payment;
—What should be the method of payment; and
—What should be the locus of the rate determination decision.

RATES OF PAYMENT

The elements of cost which should be evaluated in calculating rates of payment for health care institutions have been delineated in the American Hos-

[1] The following statement provides a foundation for future and perhaps more detailed policy statements on specific aspects of health care financing.

pital Association's *statement on the financial requirements of health care institutions and services.* This *statement* identifies the community obligations of health care institutions and presents a reasonable model for structuring adequate rates of payment to institutions which meet the requisite obligations. As such, it should be supported by Blue Cross as a reasonable guide to plan/provider negotiations.

In implementing the *statement*, it should be recognized that the proposed method of rate calculation neither demands nor presupposes a single rate of payment for all purchasers. Rather, the method requires only that contracting agencies pay their "appropriate share" of an institution's financial requirements; i.e., each class of purchaser pays its unique economic cost.[2]

Research by the American Hospital Association, in regard to nursing care for the aged, has demonstrated that economic cost can differ significantly by class of purchaser. Similar research by Massachusetts Blue Cross has not only demonstrated the same result, but also has shown that the potential magnitude of cost differential between classes of purchasers can, in some instances be as much as 12 percent.

If the *statement's* principle of "appropriate share" is to be achieved and, if equity is to be obtained—both between payor and provider and among payors—rates must be calculated to reflect not only elements of cost, but also each class of purchaser's impact on a provider's incurrence of any particular element of cost. In operational terms, this means, for example, that:

—Cost elements, such as working capital financing, credit and collection expenses, nursing care expenses, which vary due to the business practices or characteristics of a class of a purchaser, should be reflected in payment rates on the basis of actual cost incurrence—not on the basis of a uniform distribution;

—Approved plant capital costs should be reflected in payment rates on a proportionate basis, with historical cost providing the payment ceiling and with negotiated capital advances acting as credits against future capital obligations;

—The financing of free services (patients unable to pay) should be reflected in payment rates on a negotiated basis. The economic cost concept demands that Government and other programs which have traditionally paid less than their share should close the gap as rapidly as possible;[3]

—Costs of community services, such as research and education, should be borne primarily by the community with participation by purchasers occurring only on a negotiated basis;

—Reductions of income, due to items such as bad debts, should be reflected in payment rates on the basis of actual experience and performance—not on a proportionate basis;[3]

—Payment rates should reflect measures of cost per unit of services that the provider, payor, and community agree are appropriate responsibilities of the payor.

In essence, rates must be established on the basis of each class of purchaser's economic costs and should vary, if economically justified and only to the extent of such justification, to reflect differences in cost. It is essential that all participants in the delivery system recognize this principle, for it is only by determining rates for all purchasers, on the basis of economic reality that an adequately and equitably financed health care system can be achieved. The tech-

---

[2] Economic cost per class of purchaser can be defined as the sum of the present tangible and present and future intangible costs which an institution incurs in the process of providing care to a particular class of purchaser, such as Blue Cross members. It basically consists of the cost elements outlined in the *statement*, adjusted to reflect actual cost incurrence. Blue Cross, for instance, generates, relative to other classes of purchasers, significantly smaller amounts of certain of these costs, due, for example, to its contractual agreements with providers which reduce business risk and its prompt payment practices and in some cases, provisions of working capital advances. Other factors, such as increased claims preparation time, can increase Blue Cross cost. These factors should be reflected in determining Blue Cross' economic cost.

[3] In calculating Blue Cross' obligation, its open enrollment practices, extensive conversion and transfer privileges and service benefits must be taken into account. These factors not only set Blue Cross apart from other carriers, but also reduce the amount of both free services and reductions of income by making coverage available to persons who otherwise might not be able to obtain it. This economic fact should be recognized in determining Blue Cross' economic cost.

nology necessary to implement this principle exists; its application is now needed.

Further, it is vital, if the public is to be well served, that health care institutions and purchasers meet the obligations and responsibilities set out in chapter V of the *statement*, both separately and jointly. A major dimension of economic cost must be community as well as individual institutional need.

A concern for adequate payment must be joined by concerns for short range and long range planning, effective utilization, broader benefits, public disclosure and responsible administration. It is only by combining sound financing with a recognition of and responsiveness to community needs that long run equity can be achieved.

METHOD OF PAYMENT

Ideally, the payment method not only should aid in improving—through controls and incentives—the operation of the entire health care system, but also should assure that each class of purchasers' payment equals its share of total economic cost. The selection of effective payment methods is hence critical to the proper functioning of the total delivery system.

No one payment method has emerged that combines the strengths and eliminates the weakness of all others. Of the several prospective and retrospective methods of payment that are currently in use, or being considered for use, none has empirically proven itself to be the "best" method. Much rhetorical interest and support has been generated for particular concepts, such as controlled charges (Indiana), budget negotiations (Rhode Island), prospective projection (New York), performance review (Maryland), etc., but objective evidence for decisionmaking is limited.

Compounding the matter is the uncertainty surrounding the basic policy issue of whether a single, uniform method or a pluralistic approach will produce the best long-term results. Theoretically, the use by all purchasers of care of a single method of paying providers and monitoring performance should enable both providers and purchasers to obtain operating economies. These economies should result from the elimination of procedural duplication and the simplification of administrative processing.

On the other hand, a pluralistic approach also can result, theoretically, in operating economies. Multiple payment methods, each in contrast to the other, either at a given point in time or over time, can yield total system economies, due to each method's attempt to demonstrate the best total result. The magnitude of these economies—as a result of concentrating on total expenses as opposed to focusing on a particular system; e.g., administrative expenses—potentially can exceed the economies which could be obtained through the administrative reforms of a single payment methodology. Also, we should keep in mind that any given method of payment cannot be judged in the abstract; its ultimate validation is only against contrasting approaches.

Existing payment methods should be evaluated and further experimentation should be conducted. Blue Cross fully recognizes this need and the import of its outcome, and encourages health care institutions to join with it in a series of projects to investigate both areas.

RATE DETERMINATION DECISION

The matter of the locus and design of the rate determination decision; i.e., who should participate in the rate-setting function and in what manner, is fundamental to both the operation of the financing mechanism and the larger question of the basic management character of the health care system.

Essentially, the issue centers on the relative merits of Government regulation of carrier rates and contracts, in conjunction with rigorous negotiation between carriers and providers, versus Government regulation of both carrier rates and contracts and provider rates. Several variations on each theme are possible.

Limited experience to date reveals problems with various approaches. This experience needs to be extended and systematized and innovations need to be added.[4]

Providers have been frustrated not only by inadequate payment, but also by line-by-line review of budgets, tantamount to external management of the

[4] For example, a prior notice mechanism may represent a workable approach to providing procedural safeguards.

institution. Some negotiations, in given areas, have been exemplary. Others have been marked by unproductive strife. The essential elements of success need to be distilled before any given pattern is uncritically advocated.

IMPLICATIONS

The fact of continuously rising health care costs and the potential of national health insurance have combined with several other factors to create a climate which demands improvements in the present system of financing health care. Blue Cross recognizes not only the need for reform, but also the equally critical need to establish operative models for guiding future decisions. If system-wide reform is to be effectively accomplished, however, it should be grounded in solutions whose efficacy has been demonstrated.

Blue Cross both supports and offers to join health care institutions in demonstration projects designed to identify approaches and mechanisms for improving the financing system.

As a matter of policy, Blue Cross is committed to establishing a financing system which both adequately meets the needs of responsibly managed health care institutions and is equitable to all classes of purchasers.

ITEM 2.—LETTER FROM DR. C. J. JANNINGS, IN RESPONSE TO SENATOR PERCY, DATED MAY 26, 1973

ILLINOIS ACADEMY OF FAMILY PHYSICIANS,
Chicago, Ill., May 26, 1973.

SENATOR CHARLES H. PERCY,
Special Committee on Aging,
Washington, D.C.

DEAR SENATOR PERCY: Thank you for your invitation to submit a statement for inclusion in your transcript.

As a physician in the practice of family medicine in a rural area in southern Illinois for the past 19 years I have some definite ideas as to what and where the "Barriers to Health Care to Older Americans" are and will share them with you.

More than 98 percent of all the older Americans that come to me for help with their health problems have these problems, not as a result of age alone, but as a result of an accumulation of a multitude of occupational, environmental, social, personal, dietary, and financial problems which are extremely time-consuming and expensive to remedy at such a late stage.

There are a couple of stories in the Bible that immediately come to mind which throw some light on the subject. One is the story of the wise virgins who prepared themselves with an ample reserve supply of oil for their lamps so that when the bridegroom came they were able to find their way to the festive hall and join in the celebration. The other one was the rich man that gave a wedding feast and invited guests, one of whom went without the appropriate wedding garment and was thrown out on his ear.

What I am trying to say is that in order to be a happy and healthy older American you want to avoid putting up barriers in your path on the way to old age. To illustrate what I mean, I will sketch briefly through a person's lifetime, hitting some of the highlights. For instance, what are the schools, the public health departments, the State and Federal governments doing to promote breast feeding of babies? It has been said that cow's milk (or formulas made from it) are for calves. Perhaps the tremendous amount of atherosclerosis discovered in the young men killed in the Korean War had its beginning in the fancy cow's milk formulas or just plain old cow's milk they were started on as infants. And then the Federal Government subsidizes the dairy farmers, promoting production of milk products including butter; plus most of the subsidized school lunch programs insist on cramming a lot of surplus butter, and cheese, and fat hamburger down the school children with no thought to future effect on their arteries, thus encouraging development of atherosclerosis which leads up to arterial disease such as strokes and heart attacks.

Furthermore, athletic programs in schools are designed to develop fodder for the varsity, both on the high school and college level, which in turn provides fodder for the professional and olympic caliber people. Very little more than

lip service is given to encouraging the development of maximum physical fitness for *all* school children. There is a crying neglect of the obese and the female, as well as those other perfectly normal healthy children who are not coordinated or motivated to participate in varsity athletics. Furthermore, health education in our public school system K through 12 is a farce, with some emphasis on washing your hands, brushing your teeth, taking a bath, getting 8 hours sleep, eating the basic five foods, more or less of a gesture towards sex education, one or two films on drug abuse, tobacco, alcohol, and seat belts, but in general most of the "health education" is relegated to the poorest instructor and is considered a Mickey Mouse course by the students.

The Federal Government through the Food and Drug Administration goes out of its way to take perfectly good drugs like C-Quens, hexachlorophene, and Diutensin-R off the market but turns its head the other way to avoid offending the packers and dairy interests and the public is constantly bombarded with pitches to eat more meat, milk, eggs and cheese by the Farm Bureau, thus encouraging an atherogenic diet in most Americans. Furthermore, approximately one American in five has an inherited blood fat abnormality which is quite likely to result in premature death or disability due to stroke and heart attack. This is easily detectible by a simple blood test. The State meticulously requires that every person submit to a blood test for syphilis before a marriage license is issued and says not a word about the lipoprotein phenotype of each of the parents and the possible effect of an inherited blood fat abnormality on the part of the offspring who is a thousand times more likely to develop disease and premature death on the basis of a stroke or coronary from an abnormal blood lipoprotein than he is from congenital syphilis!

Furthermore, the FDA bans cyclamates from the market for use as an artificial sweetener because of some malignant tumors in rodents fed huge amounts over a long period of time and does nothing to ban the sale of cigarettes which cause the death of 65,000 Americans each year from lung cancer plus untold numbers of cases of bronchitis, emphysema, and pneumonia in lungs weakened by excessive inhalation of tobacco smoke.

Current research has demonstrated that automobiles can be equipped with wraparound seats, roll bars, shock-absorbing bumpers, collapsible steering wheels, safety helmets, seat belts, and shoulder harnesses to make it almost impossible to kill yourself in a car, yet the FDA does nothing to enforce the use of these lifesaving devices which have been proven and are available for the past 10 years and 50,000 Americans go driving off to their death in an automobile each year, not counting the millions injured and disabled for life.

I do not believe there will ever be enough doctors, auxiliary, and paramedical personnel, and medical facilities to care for all the older Americans who need care as a result of neglect of their own health. It is about time that the Federal Government got interested in promoting optimal health in infants, children, young adults, older adults, and the aged instead of pouring money down a rat hole trying to ameliorate and correct problems presented by the chronically ill older American.

I would be derelict in my responsibilities if I did not point out to you the fact that due to the numbers and distribution of family physicians in the United States it is no longer possible to assure availability of a competent family physician for each older American. The Federal Government has given only lip service to the idea of providing such a physician while billions of dollars have been spent on research in medical schools through the national institutes of health, in chasing after cures for cancer, strokes, and crippled hearts.

Precious little has been done to encourage medical schools to turn out an adequate number of students motivated to pursue a career in family practice or to provide financial backing for teaching hospitals with family practice residencies, or to provide family practice faculty for the schools and the teaching hospitals.

I apologize for the briefness and incompleteness of these remarks but I have conveyed to you the general idea which is that in providing health care to older Americans it is better to close the barn door than wait until the horse gets out of the barn.

Sincerely,

C. J. JANNINGS, M.D.

ITEM 3.—LETTER FROM D. KATHARINE ROGERS, URBANA, ILL., TO SUBCOMMITTEE ON HEALTH OF THE ELDERLY, DATED MAY 14, 1973

MAY 14, 1973.

HONORABLE CHAIRMAN: The advisory committee to Tele-Care, our most concerned agency in the field of aging, has asked me to express some of our thoughts on barriers to medical care for the aging. I respectfully submit the following:

Distribution: Our rural population, as well as that in a great many towns and small cities is devoid of medical facilities and medical personnel.

Inadequate or incorrect health insurance: If they could afford it, most elderly do not know what the risks are, and consequently do not know how much they should spend from small budgets for health insurance. They are constantly bombarded with brochures from insurance firms offering unrealistic policies. Many of them appear to be fraudulent. Some guidelines in this matter should be made available to the aging. The spectre of long and expensive illness scares old people into unwise expenditures in this field.

Medicare: Excellent as it is, Medicare has failed to live up to its promise. It costs too much, it does not police the services rendered the patient, nor the charges made by hospitals and doctors. Often, Medicare refuses to pay the full charges, so the patient is left with the balance. Doctors are too busy and too disinterested in the costs of medical care; nurses are too few. Who really knows whether the patient got all the services for which Medicare has been billed in his behalf? An ombudsman for the patient and Medicare is needed.

Medical personnel: It appears that the mixture of preventive checkups and treatment of the ill is one barrier to the care of the aging. I am afraid it is the elderly patient who "falls between the stools" while depending on overworked doctors and too few nurses. Rumor has it, that one of our clinics told its doctors they must see 40 patients a day to sustain the enterprize. Naturally, they become more and more dependent on their nursing staffs. A few days ago, there appeared in the Chicago Tribune a report that doctors were planning a new program which would allow nurses to practice medicine under their supervision. This, it was said, would increase the doctor's productivity by 30 percent (and likely his income). A great barrier to good medical care at present is the lack of good bedside nursing. With this new plan, patients would get less and less care. Most of the current care is now rendered by "pitty-pats" (small girls running up and down halls with pills).

Lack of communication: The patient is not taken into the confidence of the medical personnel, he lacks understanding of the diagnosis, prognosis, and treatment. Often his dignity is eroded. He is made fearful by lack of explanation of the charges for his care—and how even Medicare will help him pay for it.

We need a new spirit of concern in the treatment of the elderly.

Respectfully submitted,

D. KATHARINE ROGERS.

ITEM 4.—LETTER FROM JANIE L. BLOOMER, PROGRAM DIRECTOR, TELE-CARE, CHAMPAIGN, ILL., TO SUBCOMMITTEE ON HEALTH OF THE ELDERLY

DEAR SIRS: As director of a Tele-Care program for senior citizens of Champaign County, Ill., serving approximately 400 persons monthly, in efforts to help keep them in their own homes as long as possible through a large corps of volunteers and small part-time staff, I find that much of our time is taken up with advocacy—helping the older person find his way through the maze of red tape, the proliferation of agencies and services which tend to put people into slots and cannot help them if they do not happen to fit into their neat categories.

We are also concerned that each time a new program is implemented, it is hemmed in by so many regulations and "guidelines," and in the case of the nutrition program, three thick volumes of rules, that it takes so much time trying to meet the regulations that the main goals of providing a good, hot meal with social and recreation benefits built in becomes secondary.

/The liberalization of food stamps resulted in the application form being increased from one page to eight.

The increase in Social Security benefits was just enough to make many people ineligible for food stamps, yet not enough to make up for the loss of buying power, so that their benefits were actually decreased instead of increased.

The upcoming changes in Medicare will result in the older person's having to pay more for fewer benefits, and will affect those least able to pay.

The changes in Medicare have been brought about not because of the abuse of the program by the elderly, but because of abuse by the providers of health care, therefore the wrong persons are being penalized.

The lack of provision for home cafe and home-delivered services under Medicare results in more people having to enter nursing and shelter care homes, thereby increasing the cost to the public of having to provide more of these facilities.

Social Security and IRS now allow provision for day care for working mothers, but no allowances for persons trying to help maintain an older person in the home, who may need the same type of care as a babysitter provides for the young.

As we see the barriers to good health care for the aging, the very agencies which are charged with providing the care are themselves setting up barriers which discourage older persons from seeking the help they need.

Thank you for the channel through which I can voice my frustrations.

Sincerely yours,

JANIE L. BLOOMER,
Program Director, Tele-Care.

ITEM 5.—STATEMENT FROM VICTOR J. ENGANDELA, ACSW, DIRECTOR, STATE OF ILLINOIS DEPARTMENT OF PUBLIC HEALTH (HOSPITALS AND CLINICS), CHICAGO, ILL.

THE GERIATRIC SERVICES PROGRAM

The geriatric services program came into being on July 1, 1971 in response to many unresolved questions and problems regarding the need to improve services generally for the aged, as well as to provide the delivery of specific evaluation services to impoverished and impaired elderly persons who were being admitted to State mental hospitals, the only care resource available and willing to accept them, or were simply neglected until the crisis situation occured necessitating drastic action. These are persons who in many instances had no home, had outlived their friends and relatives; who were beyond the point of resources and families. For decades the State mental hospitals had become repositories for these persons with little or no differentiation regarding individual needs for treatment and supervision.

Similarly, little attention was paid to whether a mental hospital setting was required or even appropriate, primarily because alternatives to State mental hospitalization were generally unknown or unavailable at the time of crisis. As a result, our State mental hospitals became virtually glutted with thousands of elderly patients over the years in spite of the increasing State government concern about this problem. Budget limitations, in the face of increasing demands, resulted in lowered standards of care and a diminution of needed treatment potential for the under 65 acutely disturbed mental patients, while the elderly in mental hospitals received less and less attention. Legally the mental health code had provided for the admission of the elderly to State mental hospitals who could not care for themselves, whose relatives and others were unable or unwilling to care for them and for those elderly persons whose behavior had been described as "psychiatric," often by persons unqualified to make this determination.

Increasing dissatisfaction with prevailing conditions resulted in the passage of the Copeland bills, the gist of which is reflected in the Mental Health Code Amendment (1969) which includes as part of the definition of a "person in need of mental treatment" the statement that this term is to specifically exclude a person whose mental abilities have merely been weakened or impaired by reason of advanced age (section 1–11). A further amendment (section 3–7), provides for a preadmission examination, referred to as "PAE," which specifies that hospitals ". . . require or provide a comprehensive physical and mental examination of that person and a study of his family and community situation. This preadmission examination shall be used to determine whether some pro-

gram other than (mental) hospitalization will meet the needs of such person with preference being given to care or treatment in his home community."

While this legislative help was much needed it did not resolve the complex problems that remained. Nursing home beds were still in short supply and no other alternatives existed for many oldsters. Even if a needed nursing home bed was available it was virtually impossible to obtain completed arrangements for the public aid support which is needed for most placements within the legal specified time for the completion of PAE (7 days).

Out of this confused situation the following needs were identified by the pilot project for community placement of geriatric patients which had been set up at Chicago Read Mental Health Center in 1970.

The need to:

(1) Avoid unnecessary hospitalizations of oldsters in mental hospitals.

(2) Have a comprehensive examination of each patient with due attention to his medical, social, and financial needs as well as the common presenting problem of mental confusion in crisis.

(3) To identify and resolve the financial and social problems which precluded implementation of plans for needed care and supervision.

(4) To resolve interagency difficulties which delay or prevent service delivery because of different time modes of operations and differing imperatives and priorities.

(5) Lastly, and most importantly, to provide in a better way general services of all kinds for our aged including linkage to programs and resources from the local, federally, and privately supported agencies.

With these goals clearly outlined, the geriatric services program was developed in July 1971. Program staff was pooled from three service agencies, Illinois Department of Public Health, Illinois Department of Mental Health and the Illinois Department of Public Aid (locally, the Cook County Department of Public Aid), so as to promote on-the-spot interagency collaboration. Old basic assumptions were overturned and new operational structure developed in order to insure development of appropriate quality, new and better ways to serve patients. One floor (52 beds) of the Public Health Hospital at 1919 Taylor Street in Chicago, which had just been closed out as a TB hospital, was chosen to house the program, providing a more appropriate, acceptable general medical setting for the evaluation. A service model which could be utilized by others, particularly other general hospitals, was designed.

The program, with Illinois Public Health leadership, has functioned as a workshop for better understanding of the moderately and severely impaired aged, for expansion and development of alternatives to institutionalization, and for interagency collaboration of efforts toward the common goal of prompt, effective service delivery.

Since July 1, 1971, over 2,500 elderly persons have been served by the program. Of these persons more than 275 were able to return to their own or relatives home, and arrangements for long-term care were completed for over 1,600 persons. Only licensed facilities were used providing various levels of care and supervision as needed for each individual based on a complete evaluation of each case by a team of physicians, nursing-care specialists, social workers and financial caseworkers. The patients served came from various referral points including mental health facilities, both at the point of intake and after some mental health hospitalization; community agencies of all kinds; the police departments of Chicago and surrounding suburbs; emergency rooms of general hospitals and from families struggling with the problem of providing care for the severely impaired aged relative.

Current goals now being planned will broaden the range of service and care options necessary to meet the specific needs of each person, including the linkage of all available city, Federal and private metropolitan Chicago social services to the aged.

ITEM 6.—STATEMENT FROM DR. ALFRED KAMM, COMMISSION MEMBER, SENIOR CITIZENS COMMISSION, SPRINGFIELD, ILL.

May 24, 1973.

Our society is negative toward elderly people. It is youth oriented; people are rated by their work productivity—their job or their position. The retired person in our society becomes a nobody.

Numerous health barriers stem from this negative attitude of our society toward elderly people. When service programs are handed out whether for health or something else, the old folks are at the end of the line.

Specifically, the negativism which the elderly face is very bad for their mental health and that leads to a great variety of psychosomatic problems too numerous to mention because they vary from person to person. The main reason mental hospitals were called snake pits is because of the treatment received by the older patients. A little misbehavior or forgetfulness on their part and they were labeled senile. Currently, many elderly patients have been moved out of mental hospitals into nursing homes or some other type of residence where they can spend their last years out of the way of community living. There is much that needs to be done for the elderly to prevent mental health problems. With adequate counseling services and psychiatric help, our older people could remain in their community to live a happy and useful life. Sometimes that calls for cooperation from the close relatives which is not always easily obtained.

An important contributor to mental health and psychosomatic problems is isolation. If some way could be found to get these "loners" involved in meaningful and satisfying activities, most of their depression, anxiety, and physical ailments would disappear.

Not only is the public negative toward the elderly but doctors fall into the same attitude. The patient senses that and the treatment program does not come out with the best results. How many doctors will give a senior citizen a reduced fee for an office call?

If doctors and society would treat the elderly with the respect, courtesy, and dignity they deserve, many of our health problems would disappear.

An important health barrier faced by the elderly is the lack of education about the changes that must be made in our program of living when retirement comes to us. Specific information is needed before retirement about methods of health care and sources for help. Participation in such preretirement courses should be mandatory and free. Our junior colleges could easily assume the responsibility of sponsoring such courses regularly.

Most important of all is the fact that whatever is done to improve the program of health services for the elderly is also good for all our people. They are all getting older and hopefully, will become senior citizens some day, and then will benefit from the improved public attitude, better health services, and fewer barriers to the achievement of the good life through better health.

ITEM 7.—CASE HISTORY, PROJECT LIFE,[1] SENIOR CITIZENS OF SANGAMON COUNTY, INC., SPRINGFIELD, ILL.

The Red Queens Race

The following case history comes from the office of Project LIFE, the area agency on aging located in Springfield, Ill. What follows has been done without the knowledge and consent of the party involved. The name has been changed because the woman was afraid of causing trouble for herself. A typical state of fear for many elderly.

Mrs. Crane has lived in her apartment for 25 years. She is affected by two eye problems. One is retinis pigmentosis, which eliminates her peripheral vision. She also has congenital cataracts which limits the rest of her vision so that she cannot see at all without contacts. Because of her vision impairment, Mrs. Crane has her apartment arranged so that everything is accessible to her and always in the same place. With people, security is gained by keeping the surrounding environment under control. With the blind and nearly blind, security is gained by keeping the surrounding environment in order and stable. It is well known that threatening a person's security, especially that of an elderly lady living alone, can affect a person's inner stability and mental health. This in turn can affect her physical health, as is shown by the number of elderly who die soon after entering a nursing home in relatively good health.

Up to January she was paying $55 a month for a three room apartment. The landlord of the apartment building raised the rent to $65. The building is

---

[1] See statement by Margaret L. Summers, p. 296.

situated close to most stores. Mrs. Crane is 65, retired, and receives a fixed income of $126 from Social Security. She has no other source of income and a negligible savings.

The building came under new ownership and a remodeling program began. Soon rumors spread of a rent increase. Now that the rent controls have been lifted the rents in this building have increased: In fact, Mrs. Crane's rent jumped 115 percent, from $65 to $140.

What did Mrs. Crane do? Well what would you do?

Mrs. Crane is an elderly person on a fixed income that is below the national poverty level. Housing in Springfield is hard to come by. The Springfield Housing Authority is just now starting on the list of names from 1970 of those who applied for housing. Rents in Springfield are exorbitant, and her location for an elderly person can't be beat if she is to remain independent and live the life she has led for the previous 25 years. (Mrs. Crane, like many elderly, does not own a car and must live close to stores and small shoppes. It is hard for her to take advantage of sales at outlying shopping centers.)

Mrs. Crane went to her new landlord again and touched his heart. Her rent was reduced to $120, a $55 (84 percent) increase over her original rent. Remember that Mrs. Crane's income is still $126 a month. Mrs. Crane went to public aid. She was eligible and received Medicaid, food stamps, some other medical benefits, and $55 a month. As with many elderly, Mrs. Crane should already have had Medicaid and food stamps. There are many elderly that do not take advantage of these programs because of pride (and fear of public aid). However it is clear that the $55 in hard cash every month goes directly to the owner of that building. The question becomes: Who is on public aid?

Appendix 2

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing a form was made available by the chairman to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR PERCY: If there had been time for everyone to speak at the hearing on "Barriers to Health Care for Older Americans," in Springfield, Ill., on May 16, 1973, I would have said:

The following replies were received:

HILMER S. COTTINGIM, SALEM, ILL.

(1) I sincerely believe Congress should remove the $72 first hospital entry fee from Medicare, or at least reduce it to take care of those individuals who are on a low income.

(2) It should be written into the Medicare agreement certain provisions for a limited amount of drugs, and then urge the establishment of numerous Medicare pharmacies across the national level that will fill prescriptions at a reduced rate.

(3) If older Americans do not have the financial assets required to see a doctor, buy drugs, or go to a hospital, make the food stamps available to them free, thus making more of their actual cash available to see a doctor or secure medical care. This would not apply if their income was at a certain level that would enable them to receive medical care and purchase food out of their income.

(4) Each and every village, small town, or city, or urban areas, be given the necessary funding to provide transportation to the senior citizens to do their shopping, go to see a doctor, secure drugs, attend church, this will take them out of their homes, get them into the mainstream of life again, and keep them out of nursing homes.

You are certainly to be commended by the people of this great State for the part you are taking in bringing these benefits into reality and we well know it is an uphill battle, but encouraging to know you are getting results.

You recall the 3 percent cost of living was made law last year when the 20 percent in Social Security became effective, but why was this one item of cost of living postponed until January 1, 1975?

Our organization here in Salem is functioning but we are only in our second year, and we have many more goals to attain to truly be of service to our senior citizens, who are not a group to be pampered, they have pride and individuality plus their security, which adds to their years of life.

Best wishes for the good work you are doing, we are all for you 100 percent.

Sincerely,

HILMER S. COTTINGIM,
Secretary.

MARGARET HOWSE, SPRINGFIELD, ILL.

This conference was extremely worthwhile. There should be more such conferences located about the State so that more people can attend. It might be

possible that they be set up in college areas and that students working for degrees in social work might participate and organize the meetings and possibly use the material and information so gathered for their theses, et cetera.

I am especially thinking of southern Illinois where the shortage of doctors and information is deplorable. Hardin County, for instance, has two doctors, both located at one extreme end of the county.

MARY E. WESTERFIELD, MOUNT CARMEL, ILL.

Please give to those on Social Security the same as those on welfare, as they get their glasses, their teeth, their hearing aid and hospital bills all paid, and we, the elderly have to pay for everything only what the Medicare pays. On the hospital bill some old people haven't even got the money to pay to go into the hospital. I asked for help not long ago to help buy me some new teeth as these I have, I have had for over 40 years and the gums are all broken off, but I was refused because I had saved enough money to bury me. But they keep a lot of lazy men that are able to work and a lot of women that have a bunch of kids without being married.

MARY M. WERNER, WITT, ILL.

I just hope you can do what they talked about, such as cheaper taxes, medicine cut, glasses, hearing aids, dentists cut, transportation cheaper and also for the ones who are retired at 60—they should have the things I mentioned cheaper too. If they need help at home, Meals on Wheels and all are very fine. Sure hope you can put it all through and help on the chiropractor treatments too. They are very high in price.

BULAH CLARK, CROSSVILLE, ILL.

I do not receive Medicare, because I am not old enough yet. I get Social Security on disability, some days I could do light work and sure could use the money, but because it is on disability, I can't work. I am keeping my American Republic insurance paid up. What it doesn't pay of hospital, drugs and doctor, the Illinois public does.

I live in Crossville, White County, in the housing project. That is one thing the Government did that is very good. Although the rent went up some and food stamps cost more after the raise in Social Security, it is still a nice place to live. But after the rent, food stamps, insurance, and phone bill are paid, I never have more than $5 left for other things. In May I bought a new pair of of slippers, and I would not have been able to make the trip to Springfield if my niece had not given me the money. Carmi, White County sure herds the public housing. I go to the "Ant Hill" senior citizen center. We invite the nursing home people 1 day a month and give them a noon meal, and play and sing for them, they seem to enjoy the day. We have lots of fun, along with the work. We could all use more help to pay the bills.

MAGGIE L. CHITTY, HERRIN, ILL.

I think something should be done for us elderly people. I am 77. October 16 I will be 78. I shouldn't complain I guess when I see others worse off than me. Two years ago I kept having big blue spots on my arms, legs and hips. My doctor put me in the hospital for 3 days to run tests. What they cost me I won't repeat. Then they sent me to Corbondale Clinic. I went there each month two times for tests on they said a rare blood. Taken two tests for leukemia. Thank God I didn't have it, but had phynisimia anemia. Have to have B12 shots twice a month for the rest of my life, $5 each shot and if I have to have a check from the doctor, that is another $7 to $12. I broke my wrist and hand 1½ years ago. Had to go to hospital a while as I live alone. That cost was plenty. When the doctor that set my arm discharged me, I had to pay him $70. I asked him to send it to Medicare. He said all bills were paid to doctor, so

when I got my check from Medicare, it was $55 so I didn't pay a lot of my bill. My sister and her husband are under doctor care and their income is small and prescriptions and doctor takes most of their income.

I enjoyed the comments at Springfield. Please excuse writing. I have developed arthritis in my fingers since I broke my wrist and hand.

MABEL H. LANE, MOUNT CARMEL, ILL.

Cut out a lot of unnecessary spending for things they do not want or need and channel the expenses of these things for things they do need such as more funds for doctor bills and hospital expenses. Thus cutting down on what is deducted from their Social Security checks to Medicare. Money they cannot afford to have deducted. With prices what they are today they just don't have enough to meet all the expenses for food, drugs and a place to live, especially those with small Social Security checks. At the rate Social Security tax is being taken from the checks of those who work, I believe more of our medical expenses could be met.

I do appreciate the good things such as hot meals and transportation for those who need a way to doctors and food and what you are trying to do. Thanks a lot.

EDRIE MCELYEA, CARMI, ILL.

It's time I sign up for Medicare but I did not get any increase in Social Security so I don't have enough to pay it. I've not been in hospital for a long time and I couldn't afford to go at today's costs.

Thanks for your great work for senior citizens.

ESTHER L. BERRY, JACKSONVILLE, ILL.

Some kind of blanket national insurance for health of retired persons. I am retired postmaster of a 3d class office (1966). I think annuities under $10,000 should be exempt of Internal Revenue to retired persons.

JOAN BRINEGAR, CHAMPAIGN, ILLINOIS

I would have made three recommendations.

I. (a) That purveyors of medical services receive payment from Medicare for services rendered—not Medicare clients; and (b) that Medicare clients pay Medicare their fair share of medical costs.

Reasons: Old people can't handle current paper work. Makes Medicare more understandable. A good method of keeping track and monitoring costs.

II. That Medicare provide personal counseling to Medicare clients on: (a) Medicare benefits, etc.; and (b) supplementary private health insurance which can be purchased.

Reasons: Medicare too complex. Older persons bombarded by private insurance companies to purchase their insurance—one friend purchased two identical supplementary insurance plans.

III. That Medicare have authority to grant in special cases: (a) Full cost of Health care for those in financial need. (b) that extra costs resulting from medical catastrophe be paid by Medicare.

Reasons: All old people are fearful of catastrophic illness which goes on for years and years.

Personally my sister-in-law was in private care from 1956 to 1972.

HILDA C. BETSON, PEORIA, ILL.

Pensions for people of 65 years or older should be exempt from State and Federal income tax.

Illinois has accomplished this for which we are very thankful.

Federal income tax for the aged—65 and over could be eliminated for those receiving income of $10,000 or less—*or*—tax for those receiving $5,000 or less income (pensions) could be *scaled down* percentagewise.

RAYMOND C. BURWITZ, SPRINGFIELD, ILL.

Excellent meeting. I felt the structure gave a representative picture of agency involvement. I felt the one private citizen was the most enlightening and would hope further enclaves would either have more testimonials from citizens or even open to the floor as an alternative though I feel the inclusion of one or two more citizens would be more inducive to goal attainment.

EARL HORNBACK, MOUNT CARMEL, ILL.

I think there should be something done about drugs that old people need and can't afford to get. They are so high it takes money away from them that they have to spend on food and other necessary things. I think they should get a cut rate on their drugs. Many go without what they really need because of the high cost to them.

MARIE CLEVELAND, CARMI, ILL.

I think we need Medicare and no change. Can't see why anyone would want to take away from elderly people. I was at Springfield and sat in on your meeting May 16 and sure was pleased by the way you talk and feel you are going to keep helping us to get money for elderly ones.

I am 67 years old and get along okay but we have a lot who don't. Sure was glad to sit in and see you also. Governor Walker who I feel also is trying to help us and feel lot of other ones who had a part and talk. Also very interested. I am all on my own. My husband has been gone 13 years.

ETHEL GARRET, MOUNT CARMEL, ILL.

The welfare recipients get their doctor bills, their dentist and drugs all paid for; also, their eyeglasses, dentures and hearing aids. I think we Social Security people are entitled to the same. Also, the money we have to pay into the hospitals before we can enter should be done away with. Many of us do without new glasses, dentures, and many drugs because of lack of money to buy them. I am an arthritic and I also need a hearing aid which I cannot afford.

I enjoyed your talk very much at Springfield and I know you will do all in your power to help us senior citizens out. So may the Lord bless you in what you are trying to do for us.

MRS. DALE CAMPBELL, MOUNT CARMEL, ILL.

I am sure there are others that would be glad to have some help on glasses and dentures. They are so expensive now they almost out of reach for some of us who need them badly. I am one of these lucky ones who don't have to pay out too much for medicare but would like to see those who do get some help on paying their drug bills.

I do thank you for all you are doing for us and enjoyed your committee meeting at Springfield.

HAROLD R. CRACKEL MOUNT, CARMEL, ILL.

In regard to the aging meeting in Springfield May 16. There isn't enough sufficient time. The aging people does not have enough pension the average

pensioner only get about $150 per month average. The doctor bill and hospital are raising every day. I would like to see a change. Everytime we get a little raise Medicare and insurance go up to offset the raise.

MARY ALLEN, CARMI, ILL.

It seems to me that if the people on low fixed incomes did not have to pay so much on their hospital bill before Medicare paid anything that they would be better able to have hospital care earlier and maybe take care of an illness in its early stage before it became worse and insight thereby necessitate a longer hospital stay later thereby costing Medicare more in the long run.

FRANCES M. BROWN, MOUNT CARMEL, ILL.

I do not pretend to have the solution to the problem, but something *must* be done to provide transportation costs, costs of doctors, health services, medicines and drugs for the elderly, within a reasonable price range they can afford to pay on limited income, especially in this inflationary period.

MARIAN L. ASCOLI, CHAMPAIGN, ILL.

(1) Maintain and improve rate of contribution of Medicare for health care of the elderly, preventive, supportive and long term as well as crisis.

(2) Increase provision for and support of home health aids, including long term care. Provide preventive programs of nutrition, health education and health screening services.

(3) Make home delivery of medical services available, develop extended care medical teams.

(4) Increase public or not-for-profit support of a wide spectrum of living arrangements with the provision of auxiliary services from individual homes close to needed services; planned garden or apartment dwellings with recreation, activity and service provisions available, through small group joint living arrangements with some nursing supervision to shelter and nursing care where there remains a chance to maintain individual dignity.

(5) *Reverse the Trend* to use shelter and nursing care facilities individually for severely retarded, young or old or seriously disturbed or those who have become irreversibly withdrawn through senile deterioration (*indiscriminately*) together with the fearful person in need of mainly physical nursing care. The person with depleted physical strength becomes withdrawn and loses the will to improve under the incomstances described. The rights of the retarded and the disturbed should be protected by specialized individualized services. The theory that these persons gain through proximity to the normal person is *not* operative in the nursing home. The ailing handicapped older person fighting to maintain his or her own self respect has not the strength to withstand the onslaught of confusion vested in his environment and becomes fearful and withdrawn.

(6) Remove home lien requirement from Medicaid, old age or disability assistance.

Appendix 3

STATEMENT FROM ROBERT J. AHREN'S DIRECTOR, MAYOR'S OFFICE FOR SENIOR CITIZENS, CHICAGO, ILL.

May 28, 1973.

SOCIAL AND ECONOMIC PROFILE OF THE ELDERLY IN ILLINOIS

I. INTRODUCTION

Societal changes.—The United States, a country which has long worshipped the youth cult, can no longer afford to ignore its older citizens. We must confront the stark fact that our overall population is steadily growing older and respond to it with social policies that reflect a public concern and public responsibility for all citizens, both young and old.

Since 1900, the percentage of persons in the age group 65 years or older has increased from 4.1 percent to approximately 10 percent of the total population of this country. Each day there is a net increase of 900 persons in this segment of the population. Projections of the population of the United States estimate that the number of elderly persons will increase from 20 million in 1970 to 23.5 million in 1980, 27.5 million in 1990 and 29 million in the year 2000.

The picture in Illinois is comparable to that of the country. In 1970, roughly one out of ten persons living in the State were 65 years of age or older. Projections indicate that the State's elderly popuation will increase from 1.1 million in 1970 to 1.2 million by 1980 and that they will then make up 10.6 percent of the State's total population.

While the older population as a whole is growing more rapidly than the total population, the age group 75 years and older is increasing more rapidly than the 65 and older age group as a whole. In 1970, close to 40 percent of the older population was 75 years of age or older.

The longer life expectancy of females accounts for the fact that in 1970 there were over 138 females per 100 males in the total older population. This disproportion is expected to rise to 150 to 100 by 1985. In 1968, almost 54 percent of all older women were widows.

Elderly men and women reside in all parts of the country and State-central cities, suburbs, and rural areas. As of 1970, the percentage of elderly persons to the total population was 9.4 percent in Cook County; 10.3 percent downstate. Persons 65 years of age and older comprised more than 14 percent of the population of 47 counties in the State in 1970. The age group comprised less than 10 percent of the total population in only 17 counties.

The prevalence of faulty stereotypes of our elderly citizens probably helps to account for our society's failure to respond to the many and varied needs of this segment of the population. While it is true that older persons have more hospital stays and more days of some disability than do persons under age 65, the vast majority of older people can manage to live successfully in the normal community. In our social planning we must recognize that the elderly are a diverse and changing population, having a broad range of problems. The 1971 White House Conference on Aging addressed itself to a discussion of these problems and made recommendations for action.

TABLE I.—STATISTICS ON ILLINOIS' POPULATION AGED 65 YEARS AND OLDER 1960 AND 1970

	1970		1960		Percent change, 1960-70
	Number of 65 plus	Percent of 65 plus	Number of 65 plus	Percent of 65 plus	
Total, both sexes	1,093,654	100	974,923	100	+12
Males	451,365	41	439,095	45	+3
Females	642,289	59	535,828	55	+20
White	1,009,811	92	920,108	94	+10
Nonwhite	83,843	8	54,815	6	+53

Source: U.S. Bureau of the Census.

TABLE II.—STATISTICS ON ILLINOIS' POPULATION AGED 75 YEARS AND OLDER 1960 AND 1970

	1970		1960		Percent change, 1960-70
	Number of 75 plus	Percent of 75 plus	Number of 75 plus	Percent of 75 plus	
Total, both sexes	421,368	100	319,500	100	+32
Males	160,406	38	135,795	43	+19
Females	260,962	62	183,705	57	+42
White	395,437	94	303,524	94	+30
Nonwhite	25,931	6	15,976	6	+62

Source: U.S. Bureau of the Census.

Income

Lack of an adequate income continues to be the most important problem facing a majority of the elderly in this country. Even with recent increases in Social Security benefits 3 million elderly or about one out of every six persons over 65 has an income below the poverty index as defined by the Social Security Administration. When the estimated 2 million elderly persons who would be in the poverty category, if they did not live with families whose incomes are above the poverty threshold are included, the number of impoverished elderly swells to 5 million—roughly 1 out of every four persons over 65.

The poverty line as defined by the Social Security Administration is a rock-bottom standard projected to be $2,100 a year for a single elderly person and $2,640 for an elderly couple. Millions of older people who are not classified as poor according to this standard are living on incomes which are inadequate to meet their needs.

The Bureau of Labor Statistics study, "Retired Couples' Budget for a Moderate Living Standard" is one measure commonly used in assessing the adequacy of incomes to meet needs. The kinds of purchases allowed by this budget indicate that it provides for an extremely modest standard of living: one-half pound of meat and less than two eggs per day for a couple; a replacement of the man's topcoat every 9th year; four local bus trips per week for the couple every 4 weeks. The most recent data available indicate that nearly half of all self-supporting retired couples living independently in urban areas do not have incomes adequate to meet their needs (see table 1-A). Estimates based on national statistics indicate that there are close to three-quarter million aged in Illinois with incomes less than that defined as a "moderate" level of income.

TABLE 1-A.—SUMMARY OF ANNUAL BUDGETS FOR A RETIRED COUPLE, AT THREE LEVELS OF LIVING, URBAN UNITED STATES, AUTUMN 1971

Item	Lower budget	Moderate budget	Higher budget
Total budget	$3,319	$4,776	$7,443
Total family consumption	3,176	4,484	6,592
Food	942	1,255	1,579
Housing	1,160	1,673	2,620
Transportation	225	438	797
Clothing and personal care	267	429	650
Medical care	424	427	429
Other family consumption	158	262	517
Other items	143	287	566
Personal income taxes		5	285

Most of the older people who are poor did not become poor until they were old. Studies show that retirees' income drops by about 50 percent at retirement but that the needs of the family do not decline substantially at this time. Because of their relatively fixed incomes, older persons who are poor when they retire, will in all likelihood remain poor. If they are not poor when they retire there is a great likelihood that they will become impoverished in their old age.

Sources of Income

Although money income for the aged is derived from a variety of sources, retirement benefits remain their primary source of funds (see table 1–B). The relative importance of income from employment showed a steady decline during the decade 1958–1967 dropping from 37–38 percent to 29–30 percent. Increased life expectancy and earlier retirement mean that savings must be stretched over a longer period of time and therefore may be becoming a less adequate source of income than formerly thought to be.

TABLE 1–B.—INCOME SOURCES OF U.S. POPULATION AGED 65 AND OVER IN 1967

[State data book on aging, 1970, table 2210]

Source of income [1]	Percent of persons 65 plus having some income	Percent of aggregate money income from specified source
Earnings from employment	27	29
Wages and salaries	21	
Self employment	8	
Retirement benefits	89	46
Social Security	86	34
Government employees	6	7
Railroad retirement	4	5
Private pension	12	
Veterans benefits	10	3
Public assistance	12	4
Income from assets	50	15
Unemployment insurance	1	3
Private annuities	2	
Contributions from relatives and friends	3	

[1] Persons may receive income from more than one source.

Social Security benefits, originally established as a supplement to private pension income are the main source of income for the older population. Even with the recent increase Social Security benefits still provide an income well below the moderate standard of living.

It is clear that ill health and voluntary retirement are not the only important factors behind the steady decline in the number of elderly persons who are in the work force (see table 1–C). The fact that in Illinois in 1970 only 183,566 persons aged 65 years or older were working is clearly due, in part, to compulsory retirement and age discrimination. Records from the Illinois State Employment Service which show that in 1970, only 1,122 of the 7,202 persons in the age group 65 years and older who applied for employment under the older workers program were placed in jobs given strong support to this explanation.

TABLE 1–C.—ILLINOIS RESIDENTS 65 YEARS OF AGE AND OLDER PARTICIPATING IN THE LABOR FORCE

	Percent
1950	42.4
1960	33.7
1970	16.5

National data indicate that employment problems begin for the older worker long before he reaches 65, the age at which he can collect full social security benefits. Beginning about age 45, unemployment increases, occupational mobility is seriously limited, and long term joblessness rises sharply. At the end of 1970, one out of every four unemployed workers 45 years of age or older was out of

work for 15 weeks or longer. This contrasts with one out of six for younger individuals experiencing the same length of unemployment.

Employment policies which are forcing persons out of the labor force at a younger age tend to counteract recent improvements in Social Security. Larger numbers of people are finding that they must apply for Social Security payments before reaching age 65. They will never be able to collect the maximum level of payment for which they would have been eligible had they waited until reaching age 65.

The department of public aid records indicate that as of December 1971, 70,502 older persons in Illinois were receiving benefits under the old age assistance program. With the enactment of the recent 20 percent Social Security increases many people formerly receiving these public aid grants became ineligible for them. Many others saw the size of their public aid grants cut down considerably. For these people, the promise of a significantly improved income through an increase in Social Security benefits was never fulfilled.

Private pension plans provide some income for only 12 percent of the elderly population. The fact that a far greater percentage of older persons, expected to receive private pension benefits when they retired, is well documented.

A number of legislative proposals calling for pension-reform are presently before Congress. However, to this date, there is nothing to guarantee that persons now entering the 65 and over age group will have any greater protection against misrepresented and mismanaged pension programs than the present older population.

Housing

Elderly persons report that housing is one of their greatest concerns in life. Two primary factors which affect their concern over housing are: (1) Their limited income; and (2) the inadequacy of available housing.

Increasing real estate taxes and costs for basic needs devour the relatively fixed income of the elderly. The cost of housing and related expenditures account for more than 30 percent of the household income where the head of the household is 65 years of age and older. When the real estate tax rises, and the cost of home maintenance increases, the difference must be made up elsewhere in the budget because the income remains relatively stable. Over 92,000 of the Illinois households headed by elderly persons reported that the pay in excess of 35 percent of their income towards rent.

Researchers have found that elderly persons tend to report that they have been long time residents (20 years and more) of their current neighborhood and are unwilling to move from the home in which they reside. The most frequently cited reasons for unwillingness to more are: (1) General satisfaction, (2) neighborhood characteristics, (3) community facilities, (4) social ties to family or friends, and (5) house characteristics.

Senior citizens who are forced by inflationary pressures and/or urban development to leave their residences of many years encounter great difficulty in locating suitable alternative living quarters. The elderly person who must relocate is often faced with the trauma involved in readjustment to a different environment. Available housing within the means of the aged is very often in a community different from the one to which the elderly had become accustomed. The upheaval of one's lifestyle has a traumatic affect on elderly persons who must move, the familiarity of one's neighborhood becomes an alien land, the close friends and neighbors are left behind, the community facilities which once were almost taken for granted are lost, and the physical arrangement of the home are altered. These changes lead to a feeling of despair and isolation in the elderly person who once had a full active life.

The Illinois Housing Development Authority (IHDA) conducted a study on the housing needs for the State of Illinois. As a result, IHDA estimated that more than 113,000 additional standard units were needed annually for the decade 1970–1980 to meet the housing needs of the growing population of Illinois and to replace substandard housing. According to the 1970 census, there were 120,000 more elderly Illinoisans in 1970 than there were in 1960, an increase of 12 percent. The 1970 census also showed that households headed by an elderly person occupy over 26,000 of the 166,000 (or more than 16 percent) of the substandard housing units in the State of Illinois.

Federal and State subsidy programs account for about 27 percent of all authorized new construction in Illinois. There were 18,650 low rental dwelling

units for the elderly throughout Illinois as of August 1970. There are more than 20,000 persons on waiting lists through the State for low rental dwelling units for the elderly. For some locations the estimated waiting period from application to actual tenancy is between 3 and 5 years. The current moratorium on Federal housing programs effectively puts an end to more than one fourth of new construction in Illinois. The elimination of these programs means that the elderly will experience greater difficulty when they seek decent housing.

Health

Health care is one of the top priorities listed by the elderly in any survey of their needs.

The elderly are not a homogeneous group. Each is an individual with unique capabilities and needs. Health care problems of the elderly include those arising from inadequate income, substandard housing, lack of education, poor environment and isolation.

More than 80 percent of persons age 65 and over have one or more chronic medical conditions, but only about 4 percent of the elderly are institutionalized. Even with several chronic conditions most elderly persons are able to cope with their medical problems and maintain a life within the community in which they have been long time residents.

Of the noninstitutionalized elderly approximately 8 percent are homebound and bedfast and another 6 percent are severely limited in their mobility. Many middle aged children are bearing the financial and emotional burden of caring for the homebound elderly while at the same time attempting to educate their children and prepare for their own retirement. Even at age 65 many retired persons are still caring for an aged parent.

Our inadequate and fragmented health care system is designed to serve the acutely ill person and therefore fails to meet the special needs of the elderly person with a chronic illness. Even if they know where and how to seek care the elderly are often unserved or not served well. Many physicians dislike serving aged persons. Comprehensive quality health care at reasonable cost is generally not available.

Fewer and fewer private physicians are willing to serve the rural community and the inner city of the large urban area. Most physicians refuse to make home visits. To obtain medical care the elderly person must frequently travel a long distance, but transportation may not be available.

For many elderly persons health care is available only at an impersonal clinic where staff is unsympathetic to the special needs of the elderly. Health care is usually uncoordinated and an individual may be receiving medication from several physicians at the same time.

Although elderly persons are subject to a multitude of mental health crises, the community mental health centers usually give low priority to their treatment.

Inadequate nutrition is a serious health problem for older people.

Many elderly persons do not eat adequately because they cannot afford to do so, while others, who are economically better off, do not eat well because they lack the skills to select and prepare nourishing and well-balanced meals, have limited mobility which may impair their capacity to shop and cook for themselves, and have feelings of rejection and loneliness which obliterate the incentive necessary to prepare and eat a meal alone. These and other physiological, psychological, social, and economic changes that occur with aging result in a pattern of living, which causes malnutrition and further physical and mental deterioration.

A full range of supportive services is rarely available to maintain the individual in independent living as long as possible. Absence of services such as home health care, transportation, homemaker services, home delivered meals, chore services, friendly visitors or telephone reassurance can result in unnecessary institutionalization. One Illinois study estimates that a third or more of the residents of long-term care facilities are inappropriately placed.

Although only about 4 percent of the elderly population is institutionalized, most elderly persons dread the possibility. Reports of shocking conditions in nursing homes cause anxiety about selection of a facility when placement is necessary. The high cost of institutionalization is a source of worry even to those with more than adequate financial resources. Medicare benefits are

limited to skilled nursing care for a short period. When their assets have been exhausted due to a lengthy stay in a nursing home there is no alternative but to apply for public assistance. However many nursing homes refuse to accept public assistance patients and will ask the patient's family to transfer the patient to another facility. Any move is difficult for the elderly person, but a move to a lower standard of care because he cannot afford a higher level is a severe blow to his dignity.

Today older people are little better off with respect to adequate medical care at a price they can afford than prior to Medicare. Physician and hospital costs have soared. Medicare reimbursement to a physician is often less than his charge and the elderly person is confronted with a sizeable billing for which he was unprepared. Out-of-hospital drug expenses are not covered by Medicare; often the elderly person must choose between food and medicine when he needs expensive medication on a regular basis. Many elderly persons delay medical attention until a crisis develops because they cannot afford the first $60 they are required to pay under Medicare for medical expenses. Medicare benefits do not include expenses for dentures, eyeglasses, or hearing aids which are vitally necessary to maintain the total well-being of a person who requires such aids.

Health can be described as an optimum state of physical and mental well-being. Their general social and economic plight precludes most elderly from reaching this optimum state.

Transportation

The lack of transportation forces the elderly population into an immobility that is not necessarily commensurate with their overall mental or physical health. Many elderly people feel that transportation is their most serious problem. Others who name income or health as their most serious problem feel that inability to travel is the most critical effect of these problems.

Income and health factors put tremendous limitations on the transportation options of older people. In 1969, almost 45 percent of all households in the country headed by persons 65 years of age and older did not own a car. This low rate of car ownership obviously has special implications for the elderly population living in rural areas where public transportation facilities are virtually nonexistent. Because they are forced to rely so heavily on public transportation systems, older persons living in cities and suburbs are the most critically affected of all urban dwellers by the Nation's current mass transportation crisis.

Even where mass transportation facilities are operating, they are inaccessible to a large segment of the elderly population. Functions required to use public transportation such as walking to a bus and climbing the steps to board the vehicle are too difficult for many elderly people to perform.

The success of special door to door transportation services attests to the fact that the adequacy of transportation is a basic determinent of an older person's use of medical services, low-cost shopping facilities, and of his general level of activity and contact with other people. Although a number of special transportation services have been established in Illinois, they have not come close to satisfying the great demand that exists for them.

Leisure Time

Retirement provides the opportunity to "do the things you've always wanted to do," but many retirees are unable to adjust to an extra 40 hours of free time a week. When his entire life was devoted to work in order to support a family and educate his children a man had little energy or opportunity to develop his capacity for enjoyment of leisure time.

Preretirement preparation programs are designed to help an individual cope with many aspects of retirement, including use of leisure time, but these programs are comparatively limited in number.

Persons age 65 and over have a median educational level of 8.7 years. Only 16 percent were high school graduates and 5.8 percent had completed 4 or more years of college. The educational system generally gives low priority to the elderly although many are functionally illiterate. Programs in adult basic education are vitally necessary to enable the elderly to function in everyday activities, such as shopping for groceries, but these programs are the first to be cut when educational funds are reduced. The educational system also fails

to meet the special needs of older persons with higher educational levels for stimulating creative programs.

The parks and recreational systems are geared to youth and fail to serve the elderly adequately. Many leisure time programs developed by public and private agencies treat the elderly as if they were in kindergarten.

Communities fail to recognize and utilize the talents and experience of their elderly citizens. Along with loss of employment, the elderly person is faced with loss of a social role in our work oriented society.

To maintain his health and his dignity the senior citizen must have the opportunity to contribute to society by participation in worthwhile leisure time activities.

Voting Participation

The statistics presented thus far give strong reason to believe that if the elderly do not now participate fully in the mainstream of society, it is not by choice but rather because economic factors, health factors, employment policies, transportation facilities and other circumstances beyond their control have pushed them out. Perhaps their voting record is the best indicator of desire to continue to participate as responsible citizens of this country. The age group 65 years or older votes in much higher proportions than do younger age groups. In the 1970 elections, 57 percent of the nation's elderly voted, thereby accounting for 17 percent of all of the votes cast. In a recent survey of persons aged 60 years and older, residing in an urban area, 93.1 percent of the respondents reported that they were registered voters. 95.5 percent of those registered reported that they had voted in the 1968 presidential election.

In preparation for the 1971 White House Conference on Aging, community forums were held throughout the State of Illinois. A persistent theme amongst the elderly participants was the need for society to recognize the fact that persons 65 years of age or older, whether they choose to retire from employment or not, do not choose to retire from participating in and contributing to this society. They need and want special attention not for the purpose of segregating themselves from younger citizens but for the purposes of remaining an integral part of the activities of the country's citizenry as a whole.

Appendix 4

STATEMENTS AND SPEECHES* SUBMITTED TO THE URBAN ELDERLY COALITION CONFERENCE, NEW ORLEANS, LA., MAY 22–23, 1973

ITEM 1.—STATEMENT FROM ALLIE MAE WILLIAMS, RN, HEALTH PLANNING CONSULTANT, NEW ORLEANS HEALTH DEPARTMENT, NEW ORLEANS, LA.

May 21, 1973.

IMPEDIMENTS TO HEALTH CARE OF THE ELDERLY IN ORLEANS PARISH

To members of the Subcommittee on Health Care to the Elderly, I am pleased to testify again regarding the health situation of the elderly in Orleans Parish. On January 28, 1972, I was privileged to testify before the special studies Subcommittee on Governmental Operations—problems of the aging.

In the past year, a few desirable changes have taken place in regards to improved health conditions in our parish but, by no means are we satisfied. Many of the health problems for the elderly have been increased and, will continue to increase unless:

(1) A comprehensive health security bill is enacted which will take care of all medical needs of the elderly.

(2) Unless the existing health care delivery system is rationalized and its present chaotic state is eliminated.

Dignity and equality of medical opportunities, and avoidance of charity must be the foundations on which any health care delivery system for older people is built. Fragmentation and depersonalization of health care *must* be eliminated.

(3) Unless there is a sharp increase in community-based health services, which will enable the elderly to remain independent in their own homes, and which await them when they return from the hospital.

(4) Unless, some method can be found to convert the *vastness* of the major health providing agency for the aged, such as Charity Hospital into human scale, neighborhood-based geriatric clinics where quality medicine can be dispensed in surroundings available, accessible, and which will enhance the personal dignity as *well* as the health of senior citizens.

(5) Unless, the existing Medicare program is brought back to its original goals to remove the burden of medical care available to all older people 65 and over regardless of their ability to pay. To be effective, Medicare benefits must be expanded to include prescription drugs, dental services, eyeglasses, prostheses, podiatry, and expanded home health care. Reimbursable home health care should include homemaking services and escort services for situations where skilled nursing care may not be needed but home support is imperative.

I would like to share with you a few brief facts about Orleans Parish, the elderly population and their health problems:

Of particular interest is the fact that the total population of Orleans Parish has decreased by 5.4 percent in 10 years while the population of persons over 65 in the parish has increased in all race and sex categories by an average 16.8 percent.

*The Urban Elderly Coalition is an organization of directors of municipal or county offices on aging. At the invitation of the Senate Committee on Aging, representatives of the host city for their May 22–23 conference submitted statements related to "Barriers to Health Care" and discussed them with Committee staff at an open meeting. The texts of those statements are reprinted here.

The Racial Distribution

As of the 1970 census, there were 63,166 persons over 65 of which 24,131 are male and 39,035 are female. The population group 65 and over showed an increase among both races and sexes with nonwhite somewhat higher than whites. This increase in population of senior citizens continues a trend in evidence here and in other large cities around the country.

In percentages, the population over 65 increased 16.8 percent with a racial composition of 69 percent white and 31 percent nonwhite accounting for 10.6 percent of the total population of Orleans Parish.

The income committee of the mayor's task force on aging provided financial data on 50,356 of the 63,166 persons over 65 in Orleans Parish, but it shows that 60 percent of the elderly are over 70 years of age and that 30 percent are over 75. According to household incomes, the committee reported that 59 percent of the over 65 population of New Orleans has income *below* $3,000. This includes both individuals living alone and couples living alone. There are an estimated 34,000 persons over 65 living alone with an income averaging $1,600 per year. On the average, 15,000 to 16,000 persons over 65 receive old age assistance grants in Orleans Parish each month with grants averaging $73 per month. The maximum being $107. An addiitional $30 allowed for nursing care in the home.

Income

The income committee reported that less than 50 percent of the active workers in Orleans Parish are covered under private pension plans, and projecting to 1980, less than 30 percent of perosns 65 and over will be covered by private pension plans.

Housing

Report from committee revealed that older persons live to an impressive extent in homes which they own (in a survey of 1,100 persons in New Orleans in 1971, 55 percent of the white population and 30 percent of the nonwhite population over 65 owned their own homes). Frequently, however, their homes are in bad repair, too large, too expensive to maintain in deteriorating neighborhoods, or no longer suitable for health reasons. They often cannot perform do-it-yourself repairs and routine chores. The same property tax increase which buys new classrooms may force them to sell, yet when a house is the only tangible asset one can show for 75 years of living, it has a special meaning to an older person not shared by a younger neighbor.

Parallel to the income problems and needs of the elderly of the community, health problems and needs command attention. It follows logically that a person who has an income of less than $1,600 a year is not going to enjoy the quantity nor the quality of health care that a person of more substantial means will enjoy. Nor will he be able to participate in good nutritional programs and regular health maintenance activities vital to the extension of good health into the later years. Health problems common to the elderly limit their activities. An estimated 28,000 persons over 65 in Orleans Parish have some health condition which limits their activity. Limiting health conditions such as arthritis, cardiac and circulatory problems, respiratory difficulties, cancer and effects of injuries, among others.

The fact is that thousands of elderly poor, and even not so poor trying to protect savings, etc., receive poor or no health care because money is not available.

Impediments to health care of the elderly in Orleans Parish are numerous just as in other urban areas where income is the number one problem. The cost of medical care and the difficulty in obtaining health services appear to be second in rank.

The impediments include the absence of:

(1) A comprehensive range of services, medication, facilities and equipment, available to all.

(2) The absence of accessibility of the needed services in sufficient quantity and quality.

(3) The absence of continuity of services so there will be no break in care as the individuals physical and mental condition changes. This includes health promotion and health maintenance, diagnosis of illness and treatment, and rehabilitation.

(4) The absence of coordination of the various types of specialty services.

Diseases of the heart and circulatory system, arthritis, cancer, accidents, diabetes, and hypertension, are the most prevalent among the elderly in Orleans Parish. Diseases of the aging and senility comprise an ever increasing problem and result in a heavy burden on many families and individuals.

Although all persons are subject to diseases and disability it is a fact that poverty, unemployment, lack of education, mental maladjustment-disease and disability often go together and reinforce the effects of the other. The obstacles to attaining good health, therefore, are especially serious for the low-income aged citizen.

MAJOR IMPEDIMENTS

(1) A major reason for failure to secure necessary health services is a lack of resources. This may reflect the individual's, ability either to pay for care or travel as needed to the point where care may be available. Traveling to medical resources often require escort services which must be compensated for out of meager incomes of our senior citizens. It also may reflect the community's lack of necessary services and facilities.

(2) *Inadequate organization of the health care system*: The health care system is not organized in a way to achieve the best possible efficiency. There is maldistribution of personnel, competition, duplication, and gaps, and an inadequate system of quality control.

(3) *Inadequate attention to prevention*: The public and professionals alike tend to think in terms of sickness rather than health and emphasize dollar and services for crisis care rather than for health promotion or the prevention of illness.

(4) *Health Education*: Health education is not reaching the individual in such a way as to motivate him. He lacks understanding and the will to act with respect to good health habits, nutrition, accident prevention, alcohol, drugs.

(5) *Primary health care deficiency*: There is an inadequate number of general physicians trained to provide primary care, or of clinic resources appropriately organized so that an individual can receive the necessary primary care as inexpensively as is consistent with quality. The result is that care is not available promptly when needed. Very often, publicly organized programs such as clinics and various welfare and institutional programs, because they cater largely to the poor and are rarely financed and staffed adequately, often render a poor quality, impersonal type of care. When there are two separate systems of health care, one for the poor and one for the rest of the population, it is difficult to avoid a double standard which provides for the poor services which often lack quality and dignity .*A part of the solution in our own community to reduce unnecessary waiting time and expense for transportation would be well equipped, staffed, walk-in-clinic on a neighborhood basis.* The senior citizens of our community very often have to *spend up to 5 hours at our public treatment agencies for treatment that is administered in 10 minutes.*

(6) *Gaps in service programs:* There are many gaps in community health resources. There is a lack of coordination between agencies—each going its own merry way. An unusual amount of duplication of services and limited community planning.

(7) *Inadequate and often substandard facilities*: Institutional care facilities for the aged and disabled such as nursing homes, rehabilitation centers, educational facilities for training of health manpower (paraprofessionals) are often deficient. Trained personnel drawn from various minority groups and who, if they were available, might reasonably be expected to serve the low-income aged minority groups are badly under-represented.

(8) *Financial barriers*: There are many elderly citizens who are not covered by Government programs or insurance and many people who are unable to pay for the cost of medical service from their own resources. Many insurance programs finance care primarily in the acute general hospital. Such programs provide no incentive and in fact create a barrier to receiving care on an ambulatory basis. Certain categories of diseases are not adequately covered. The cost of health services have risen to a point of national concern. They are rising at twice the rate of overall consumer prices. Many of our senior citizens collect prescriptions after prescriptions without being able to get them filled.

Time will not permit me to cover all the existing barriers to the adequate delivery of health care but, attention must be given to a broader involvement of consumers in the planning and operation of health programs. May I

briefly mention some ways in which the health care system for the aged and disabled in Orleans Parish might be improved:

1. The reorganization of the health care system should consider the following objectives:

(1) *Greater emphasis upon prevention, health maintenance and rehabilitation:* This requires greater attention to health education, multiphasic screening programs under medical supervision, greater emphasis upon the primary health care concept; regular physical examinations, nutrition education to counter poor diets and obesity.

(2) *A balanced array of programs and facilities*: Improved medical centers for training research, diagnostic, therapeutic and rehabilitation services, acute general hospitals, specialized institutions, ambulatory care centers in Satellite areas and home health services.

(c) *Dental services* for those who cannot pay the cost of proprietary care.

(d) *A unitary system* not a separate system for the poor. Services should be open to all, not restricted or segmented on the basis of income or race.

(e) *Accountability* services which are responsive to community needs and subject to community control.

(f) *Citizens support* of health manpower training programs.

(g) *Protective services* to prevent the person who is seriously disturbed from attempting suicide or behaving in a way which may be dangerous to others. This includes counseling, crisis centers, and emergency hospital care.

Informational and protective services are limited in our community. Many other communities devise a standby plan for providing care and assistance to the elderly at times of crisis. Such planning includes a publicized telephone number to help, together with agency agreements as to responsibility for followup.

Environmental services should include availability of appropriate housing with incorporated features contributing to safety, independence and well-being of the elderly and located so that there is easy access to public transportation and community services. Should include tax rebates for older homeowners, reduced fares during nonrush hours in public transportation; escort services and "buddy systems" to help protect older persons on the street. Telephone reassurance, homemaker services, friendly visitor services, transportation, drugs, and medications-counseling. The creation of accessible, quality primary or ambulatory medical care programs in poverty areas.

Educational-recreational programs are important: The older person no less than others wants new learning experiences, a vocational knowledge and skills, and opportunity to develop new careers for which he may need training.

Senior citizen centers are among our major needs in our community. Everything that makes life worthwhile, that enables a person to reach his maximum potential, fosters good health. This includes education, attractive and safe housing, safety from hazards, opportunities for employment and self-fulfillment, wholesome interpersonal relationships, and the chance to become involved in activities and decisionmaking. The goal is positive health as well as the absence from disease or disability.

In spite of the many socieconomic and health impediments facing the aged population of Orleans Parish, our community is fortunate in having a sympathetic city administration who is deeply concerned about the problems. This has and is being demonstrated through the involvement of community leaders of all age, ethnic, and socioeconomic groups who have been active for a period of time on the mayor's task force on aging.

In spite of the money demands made upon the city's tight budget, for 2 consecutive years, the city has allocated $50,000 to the New Orleans Metropolitan Council on Aging, free office space and other services. Many of the city and State agencies are beginning to extend their services to the aged in spite of limited staffs and heavy workloads.

The city of New Orleans Health Department without additional budget or staff has initiated a geriatric medical clinic twice weekly in a highrise housing project with 525 elderly residents. Here, chronic and acute medical services are provided for the residents. A part time public health nurse is

also assigned five mornings a week to the geriatric clinic facility for therapeutic injections, nurse counseling, referral and followup. An eye clinic is conducted twice monthly for elderly.

Charity Hospital of New Orleans and the newly formed Louisiana Health, Social, and Rehabilitation Service Administration (super board) have recently instituted four geriatric satellite clinics for the elderly in low-rent housing projects for treating existing illnesses (both chronic and acute), including physical examinations and tests, vision and hearing screening, referral and followup.

Under the direction of the city of New Orleans Health Department, Director of dental health and the Louisiana State University, examinations of the elderly citizens are being instituted in the satellite geriatric clinics.

The New Orleans metropolitan council on aging program is a dynamic force in Orleans Parish. Though a demonstration project serving a comparatively small number of the elderly population directly, the comprehensive services are demonstrating the dire need for an expanded comprehensive program for the elderly. The program has a tremendous impact in stimulating interest, and influencing existing community agencies to become more concerned for the aged. It was through the Council on Aging that Charity Hospital agreed to initiate the satellite geriatric clinics.

The advocacy role which the New Orleans Metropolitan Council on Aging has assumed in behalf of all senior citizens in Orelans Parish is recognized throughout the elderly population as a stimuli, which has resulted in hundreds of senior citizens, not directly in need of the council's immediate services becoming involved in many civic, recreational, political and community organizational committees and programs for the elderly which have been initiated through the various action committees of the Council on Aging. To be exact, approximately 12,000. In an effort to coordinate, stimulate, and provide needed services for the eldrely, the council was largely responsible for the expanded Health services of Charity Hospital for the elderly. *2,000 elderly isolated residents are receiving direct services throughout the areawide project on aging with a projection of 3,500 isolated elderly receiving direct services by the end of 1973.*

In summary, the major impediments to health care for senior citizens are:

(1) The lack of accessibility, availability, quantity and quality of health services.

(2) Inadequate funds to provide adequate health services, health has a low priority from a budget standpoint.

(3) Difficulty in getting physicians to make home visits.

(4) Prohibitive cost of medicines.

(5) Lack of supportive health services.

ITEM 2.—SPEECH BY RICHARD P. BROWN, EXECUTIVE DIRECTOR, HOME HEALTH SERVICES OF LOUISIANA, INC.

May 22, 1973.

Barriers to Health Care for the Elderly in New Orleans

I'd like to thank Mrs. Engolia for the invitation to speak on the subject of "Barriers to Health Care for the Elderly in New Orleans." I'll address myself to matters concerning home care which is of particular interest to me since I'm the administrator of a large home health agency in New Orleans.

There are seven organizations that provide home health or homemaker services in New Orleans and I venture to say that collectively, they are or could be capable of meeting all of the needs for home care. The methods of control and financing of the providers vary to include official, voluntary, and proprietary, but one thing they all share in common is, that through one mechanism or another, they have to be paid for the services they render. In some instances, the recipient of the home health services pays for care from his own personal resources. But in most cases, the funds for services comes from the Federal Government through the Medicare program, the Federal and State governments, through the Medicaid program, and from the city govern-

ment through their home care program. Some small but very important amount of home care is provided from moneys generated by the United Fund and other philanthropic endeavors. The model area project under the direction of the Council on Aging artfully combines all of these mechanisms.

By the way, I forgot the third-party payors, the insurance companies, that is, our Blue Cross and commercial insurance carriers. But really, I didn't forget them, they forgot or ignore home care as an important alternative to institutional care. Our Blue Cross plan could probably set the pace in the community by offering in-home care as a part of basic coverage, but they won't. They continue to keep it neatly tucked in some obscure corner.

But the notion that the Blues should pay for home care is not new, it's not something I dreamed up last week, it's existed for years, and for years plans have offered the coverage in other parts of the country. I call your attention to the March–April 1972 issue of "Blue Cross News." An article entitled, "Blue Cross announces nationwide programs to improve coverage, control costs" says in part, "While traditionally Blue Cross benefits have largely covered in-hospital cost, Blue Cross plans are launching a massive benefit expansion program to make available benefits such as prescription drugs, home care . . ." And so on. We'll have to wait and see whether our local plan meets the challenge but how long can the elderly wait.

We shouldn't lose sight of the fact that right now the Federal Government is the largest direct purchaser of home care services for the elderly through the Medicare program and indirectly through the Medicaid program.

I feel quite certain that the in-home services required by the elderly in New Orleans can be provided now or developed early in the near future if the resources and mechanism were available to purchase such services.

The problems of perception of health care needs and the delivery of health services are quite complex and I would be nothing short of arrogant to say that I've simplistically solved the problem but I think I can shed some light on the artificial barriers erected and maintained by the administration and the Department of HEW.

I perceived the 1971 White House Conference on Aging as a gigantic co-opting of people who were genuinely interested and substantially engaged in activities impinging on the problems of the elderly but I tell you in all sincerity that 4,000 people didn't have to meet in Washington to discover that elderly people like all others need to have adequate, food, housing, and transportation and access to all forms of health care and that all of this must be provided so as to maintain the elderly person in the mainstream of society and with dignity to the greatest extent possible. And 4,000 people didn't have to journey to Washington to figure out that these basic needs had to be paid for and that what individual and philanthropic resources couldn't pay for would have to be funded by the Government.

If my memory serves me correctly, when President Nixon spoke at the closing session of the conference, he told Doctor Flemming that he had good news, that the Administration on Aging's budget would be raised from $50 million per year to $200 million per year, a four-fold increase. But let's put that in proper perspective, that's an increase from $2.50 per elderly person per year to $10 per elder person per year, and we all know what $10 will buy these days. But at the very time the President was telling us his commitment to the elderly, his intention to increase the AoA budget, he was already withholding some of the $50 million and making plans to impound other funds that Congress earmarked for the elderly.

I'd like to in part quote from the May–June 1972 issue of "Blue Cross News":

"MEDICARE DE-EMPHASIZES HOME CARE BENEFITS

"Medicare regulations force ailing persons into hospitals when they might be better off physically being treated at home, a report prepared for the Senate Committee on Aging said recently. The report called for changes in Medicare and Medicaid regulations to promote the use of home health care services.

"Less than 1 percent of Medicare expenditures now go to home health care and even that small portion appears to be declining. Despite lip service to the need for home health services, Medicare and Medicaid have actually fashioned serious roadblocks to the development of such services."

I tried to pass some thoughts concerning this decline on in a letter to Doctor Flemming in July of last year. It describes what I've named, the watcher-watching-the-watcher phenomenon. I'd like to read from part of the letter:

"As the administrator of an agency which is a provider of such services and as a health care professional, it seems to me that the administration is constantly discovering new limitations in coverage of Medicare benefits and invoking the words, 'the intent of Congress' in order to affect economies in the Medicare program.

"I have a gut feeling that in some areas, the amounts of money being spent to conservatively and restrictively police the program, both by the Bureau of Health Insurance, the fiscal intermediaries and the providers, is far in excess of any money that might be paid for services rendered to patients who are not qualified or who are questionably qualified to receive care under a less intense and more efficient surveillance program.

"Under the present system, the provider is screening patients to be sure that claims for services are not denied. The fiscal intermediary is screening claims to be sure that they are not accused of leniency in reviewing claims. The regional Bureau of Health Insurance is maintaining surveillance of intermediaries to be sure that they are not accused by the Bureau of Health Insurance in Baltimore of having lenient intermediaries in their region. I am sure also, that the Bureau of Health Insurance is being watched by the Social Security administration and the Government Accounting Office to be sure that they are not embarrassed by the Congress or the Secretary.

"Each watcher in watching the watcher, generally decides on the conservative side in order to protect their flanks so that the conservative attitude of each component in the chain is multiplied each time to the detriment of the provider and the consumer.

"I respectfully submit that we as a country have got to come to grips with this problem especially since we are facing an era when the Government will become a purchaser of increasing amounts of health care and will provide services to an ever increasing segment of our population. I am quite confident that you can pass this letter on to people in the various components of the system and receive an assessment that none of this is so, but the facts speak for themselves. You know that less than 1 percent of the Medicare dollar is being spent for home care and that this continues to decrease."

One of the basic problems in dealing with the bureaucratic system is that inquiries like this are typically handled by passing them on through the system to the source of the problem where a completely subjective and properly defensive response can be made. And so in response to the inquiry the Secretary provided a report to the Commissioner to be passed on to Doctor Flemming and finally to me.

I can assure you that the response did not provide any new information or relief. There is no doubt that there will be abuses and there will be misunderstanding concerning benefits to be provided under the Medicare program and there must be systems to deal with these problems but we'll be in a lot of trouble if we don't figure out a better way before we expand Federal health insurance to other segments of the population.

Several mistakes were made in the tightening of Medicare claims administration after the start of the program.

As you know, Medicare covers hospital care, extended care, home care, appliances and durable medical equipment and physician services. As I perceived it the first covered service to come under scutiny by the fiscal intermediary was extended care and in a 2-year period the number of facilities participating in the Medicare program as extended care facilities in New Orleans dropped from over 20 to 4. I would imagine that during that time, the total number of patients being cared for in extended care facilities under Medicare in a given day was less than 50 out of an aged population of about 100,000. When I met a surgeon at a cocktail party he told me that it was impossible to keep a patient in an ECF. He said that a few days after the patient left the hospital to enter the ECF, the fiscal intermediary would find that they didn't qualify for payment and then there'd be trouble. I asked him what he was doing about it, and he replied, "I'm keeping them in the hospital longer because they need some kind of care." Well, isn't that brilliant, forcing a patient to stay in the higher cost hospital longer to have a

good showing in policing the ECF program. I would like to add parenthetically, that the physician had to act in the best interest of his patient and the fiscal intermediary was only doing what was demanded of it by the regional Bureau of Health Insurance office.

Well, I felt sorry for the ECF's in those days and I was wondering when this style of oppression was going to be passed on to the hospitals. One would think that controls would be applied evenly, out of a notion of fairness or to the highest cost facility out of a notion of economy and efficiency. Well, it didn't really work that way.

Today, every home care claim and approval is examined in minute detail, each unit of service, every admission, every visit and supply item must be documented and defended. For every dollar our agency spends giving home care, I'd guess 50 cents or more is spent justifying and proving the care was needed. The claims review process is handled in such a way that it seems that the physicians and nurses working for the fiscal intermediary, even though removed in time and space from the patient are trying to substitute their judgment in the management of the patient's care in place of the patient's physicians and agency professional staff.

You can imagine what would happen to the cost of a 5 pound bag of sugar if you made the grocer dish it out to you in teaspoon lots to be assayed by both the seller and the buyer one spoonful at a time.

I think that one reasonable rule in setting up controls has been forgotten. That is, that the money saved by the Government should be substantially greater than the total cost of the controls and even more important, that the evils generated by the surveillance should not be greater than the evils to be cured. Many of these problems could be solved in the framework of the existing Medicare laws if it were the desire of the administration.

Finally, I'd like to talk about the comprehensiveness of the services available as benefits for home care under the Medicare program.

If an elderly person is to be maintained in their home, which we assume is more desirable than institutional care from a humanitarian standpoint, as well as cost, then we have to be able to supplement those services presently defined under Medicre law. The present list consists of:

(1) Skilled nursing.
(2) Physical therapy.
(3) Speech therapy.
(4) Medical social service.
(5) Nutritional consulting.
(6) Home health aide services and occupational therapy.
(7) Medical equipment and supplies.

We need to add:

(1) Homemaker services.
(2) Meals on Wheels.
(3) Transportation, and
(4) Laboratory services, and possibly others.

And we need to stand ready to take care of someone not just if they are acutely ill but also if they are chronically ill.

If someone is sick, they're sick, and they need care: their pains and suffering, and their status as human beings is not diminished by the fact that the bureaucracy has defined their needs as custodial rather than acute.

As a Nation, we have to redefine our obligation to the aged on humanitarian and social terms as opposed to the provision of an insurance policy with fine print to be changed in the form of regulations to be issued by the Secretary of HEW in response to the budgetary desires of the administration.

ITEM 3.—TESTIMONY OF MALCOLM MARTIN ON BEHALF OF THE LOUISIANA COMMITTEE FOR NATIONAL HEALTH INSURANCE, NEW ORLEANS, LA.

May 22, 1973.

TESTIMONY BY MALCOLM MARTIN

I am Malcolm Martin, an officer of the Lousiana Committee for National Health Insurance. This committee was formed last year by representatives from a cross-section of organizations in the State. The committee is an open organizations in the State. The committee is an open organization which works to

educate itself, the people of Lousiana and our congressional representatives on the need for national health insurance.

The committee is committed to the position that health care is a basic right and that the benefits of modern health technology should be available to all individuals of this country. We believe that most people now consider that the achievement of health for all should be the national goal of highest priority.

Today our health care system is far from an optimal state. High quality health care is reserved for those who can pay. Bills for health care have increased in cost faster than anything in the family budget. This can also be said for that portion of health care which is now being paid for by our Government.

But, are we getting what we pay for? No!

The United States trails most other industrial nations in every accepted standard of health. Our infant mortality is higher, our life expectancy is less (for males we rank 26th and for females, 11th). The figures for the poor are worse.

Our health system needs a complete reorganization. Our priorities are now emphasizing the cure rather than the prevention.

We believe that these problems can only be solved on the national level. We believe that health care is a fundamental right of all people. Government has a responsibility to assure that right, through the enactment of appropriate legislation to create a national system for the financing of health services.

The legislation should create a program of public/private partnership. Financing should be through the tax mechanisms to assure equity and universality. The funds raised through this mechanism should be used to pay for services provided in the private sector, thus assuring diversity and creativity in the orgaization and delivery of services.

National health should be comprehensive, including preventive, health maintenance, diagnostic treatment, restorative and protective services. There should be no financial barriers to necessary care.

The legislation should create mechanisms to establish national standards for individual and institutional providers to assure that all services financed through the program are of high quality, appropriate to the patients' need, and reasonable in cost.

The legislation should encourage the development of integrated health care systems capable of delivering comprehensive services which are acceptable and accessible to all people. The Government should invest in the general educational system of the Nation to prepare health manpower of all types in sufficient numbers to provide an acceptable standard of comprehensive health care services.

The legislation should encourage and strengthen comprehensive health planning to assure maximum use of all resources and the elimination of unnecessary or duplicative services. Consumers should be involved in all stages of planning. In addition, there should be encouragement for joint planning by all health professions for recruitment, preparation, utilization and compensation for health manpower to assure that manpower training programs are appropriate to community need.

There should be professional, intellectual, social, and financial incentives to bring about development of health manpower to those areas where it is in scarce supply.

The committee has based its comments not on any specific proposal for a national insurance program now before Congress, but rather to what it considers are the essential elements of a health care system for any program. We have listed our statements of belief and we urge your serious consideration of them as you develop this important and significant legislation. I thank you for this opportunity to appear here today.

ITEM 4.—TESTIMONY OF C. MICHAEL MOREAU, ADMINISTRATOR, NEW ORLEANS MENTAL HEALTH CENTER, AND CHAIRMAN, TASK FORCE OF THE AREAWIDE PROJECT ON AGING

May 23, 1973.

Epidemiological studies demonstrate that the incidence of psychiatric disorders increase with age: One per 100,000 under 15 years of age; 103 per

100,000 between 25 and 34 years of age; 120 per 100,000 between 45 and 54 years of age; 137 per 100,000 between 65 and 74 years of age; and 225 per 100,000 over 75 years of age.

There is a decade by decade rise of depression, including the peaking of the suicide rate in men in their eighties.

Mental health problems that we frequently find among the aging population are loneliness, multiple stress, high incidence of suicide, depression, and organic brain syndrome.

I would like to share with you specific information concerning the mental health problems of the aging in Louisiana and in New Orleans in particular. During the 1950's we experienced a major change in hospital care of the mentally ill. With the introduction of the new psychiatric medications, it was possible to stabilize many chronic patients who had been in the hospital most of their lives and to release them into the community. Unfortunately, in many cases this has resulted in merely a change of location of the back wards from the hospitals to local boarding homes.

During the past 2 years the New Orleans Mental Health Center has decentralized its mental health services into the neighborhoods. Through this process we have become aware of several such "back wards" in the community. They are boarding homes in the uptown section of the city housed in old buildings with few, if any, professional staff. Chronic patients are released to these nursing homes from the State hospitals with no followup care. The services are primarily custodial in nature with very little medical attention. One boarding home, now called a sanitorium, was once a nursing home before it lost its license for skilled care. The majority of the residents of these homes are over 65 and have no contact with persons outside the home. Due to the lack of trained staff, these firetrap boarding houses lack social, medical, and other services.

Another segment of the elderly population in New Orleans which are experiencing mental health problems are those persons who have experienced dislocation from their regular residence and are now housed in large public housing projects or nursing homes. The primary mental health problem which is found frequently is isolation. One of the major barriers that keep the elderly isolated is a fear of crime and violence. A few weeks ago a 76-year-old woman was raped and brutally murdered near her uptown residence. One of our 65-year-old patients was beaten by two young men as he left one of our satellite clinics in a housing project. He was a senile patient with chronic brain syndrome who did not understand that threat of the young men that if he did not give them a dollar they would beat him up. Frequently we have elderly persons failing to keep their appointments at the mental health center because of fear that they will be attacked on the way to the center or that their apartments will be burglarized while they are gone.

Another major problem has to do with the financing of mental health programs for the elderly. At present Medicare coverages for psychiatric disorders is unrealistically limited and must be revised. Under part B of Medicare there is a $250 limit per calendar year for outpatient psychiatric services provided by a physician. Not only does this limit the amount of services provided on an outpatient basis, but it also limits the type of personnel who can provide these services. The 90-day limit for a spell of illness for hospital care is also unrealistic in the treatment of mental illness. Fortunately, in Louisiana, deductibles for welfare patients are handled under title XIX. However, no such help is available for nonwelfare recipients.

Another problem with financing is that the two mental health centers connected with private hospitals do not receive reimbursement from Medicaid and Medicare. As a result, they are not able to treat as many indigent elderly as the State operated facilities.

I wish to bring to your attention one final problem with mental health treatment. In New Orleans it is still necessary to have an elderly person arrested before the coroner will commit the individual to a hospital for treatment. What this means is that in a situation where a son or daughter of an aging parent who may need psychiatric help but does not recognize this fact, the son or daughter must file charges against their mother or father before the coroner will order a psychiatric evaluation.

In conclusion, I would make the following recommendations for your consideration:

(1) The enactment of legislation outlawing personnel policies which require retirement at a certain age.

(2) Affirmation of the right to treatment of older people in a variety of psychiatric settings.

(3) It appears that the Federal Government will be turning over the U.S. Public Health Service Hospital here in New Orleans to the State for operation. Perhaps the State could be required to use a portion of the facility for a center for elderly persons.

(4) Elimination of the discrimination within Medicare and Medicaid and other third-party payments against emotional illness as compared to physical illness.

(5) Guarantee that moneys designated by law for improving the care of the elderly (such as Medicare) do not go into the State general revenue fund, but are used to develop improved mental health delivery systems for the elderly.

(6) All mental health disciplines should be included among those who are able to be reimbursed under Medicare for psychotherapy. These disciplines include psychiatry, social work, psychology, and psychiatric nursing.

(7) Expenses for such items as hearing aids should be covered under Medicare. Perceptual losses adversely affect mental well-being. For example, hearing loss (which is present in 25 percent of older people) is associated with the development of suspiciousness and paranoid thinking.

(8) Extension of the Community Cental Health Centers Act of 1963 or the enactment of similar legislation.

ITEM 5.—STATEMENT OF WILLIAM E. ROONEY, PAST PRESIDENT, METROPOLITAN NEW ORLEANS COUNCIL ON AGING; CHAIRMAN, MAYOR OF NEW ORLEANS TASK FORCE ON AGING

"Health Barriers for the Elderly"—they may be summed up many ways, perhaps best by saying lack of income and lack of understanding. Ironically, the programs set up at assist them—Medicare and Medicaide—fall on both of these points. The elderly badly confuse the two programs, many thinking Medicare is the part A or Hospital part and Medicaid is the part B or medical part of a vague Medicare program. In our search for catch phrases we have succeeded in confusion.

I can't say very much about Medicaid except that many people just fall short of qualifying which means an income barely adequate for health is totally inadequate for illness.

Under Medicare the elderly have seen the premium for the medical (or doctor bill insurance) part go from a minimum of $3 per month in 1966 to a projected minimum of $6.30 per month in July 1973. They have seen the deductible go to $60 before a partial payment on an "allowable charge" is made. They have seen the hospital insurance deductible rise to $72 in 1973. While Social Security benefits have been raised several times in the 1966–1972 period, inflation plus the increasing premium cost have left them worse off; the increase in doctor's charges have brought more fees to the point where they are reduced to an "allowable charge" which means the patient gets less when he gets 80 percent because he has to make up the greater difference to the doctor, unless the doctor takes assignment.

There is lack of knowledge of the deductible—many people think they have to pay $60 extra besides the monthly premium, and many think the $72 deductible on hospital insurance is a yearly premium. Many don't go to a doctor because they think they have to pay him before they can make a Medicare claim, not realizing an itemized statement of services and charges is sufficient for a claim. Some fail to file a claim because they don't have enough bills, not realizing that in some cases there is a carry over of charges from one year to the next to be applied against the deductible. We have failed to get the message to many by using technical words and confusing explanations.

In addition to this, the elderly see many gaps in the program of Medicare—no dental care, no hearing aids, extremely limited reimbursement on eye care—the very places where the elderly need reimbursement. And the one thing they absolutely cannot understand—why is there no reimbursement for prescription drug?

Other aspects of the program are not misunderstood so much as there is complete unawareness. The possibility of skilled nursing facility care after hospitalization, the possibility of home health care whether hospitalized or not—the medical profession itself is confused by the availability (or lack of avilability) of these services, and the result is they are little utilized—and when they are utilized it is for all too brief a period with the possibility of a sudden cessation and a retoactive bill. Perhaps it is fortunate they are not better understood because they might be even less used.

Finally, some elderly cannot be covered by part A of Medicare because they have not had sufficient work under Social Security. It will become available to them on July 1 at a premium of $33 per month, and they will be required to take part B at a minimum premium of $6.30. No wonder they play percentages that they won't get sick.

In closing I might mention the plight of a large number of Spanish-speaking people in this area—principally Cuban refugees, who cannot qualify for Medicare because of little or no work credits under Social Security and because, while they have been in the country for years, do not bear the technical description—"lawfully admitted for permanent residence"— they are completely out of luck.

ITEM 6.—LETTER FROM JESSE J. FULLER, TAMPA, FLA., TO WILLIAM E. ORIOL, STAFF DIRECTOR, U.S. SENATE SPECIAL COMMITTEE ON AGING

HILLSBOROUGH COUNTY COUNCIL ON AGING, INC.,
Tampa, Fla., May 21, 1973.

Mr. WILLIAM E. ORIOL,
Staff Director, U.S. Senate,
Special Subcommittee on Aging,
Washington, D.C.

DEAR MR. ORIOL: Regarding Barriers to Health Care for Older Americans, and your letter of May 14, we wish to appraise you of one case documented recently by our council.

The case concerns a widow and her expenditures documented August 23, 1971 through May 18, 1973. This represents a 19-month spell of illness just prior to her death in May of this year. This does not represent a catastrophic condition. Previous medical history had shown broken arms due to falls, overweight, diabetes, some blood pressure problem, but controlable. The deterioration commenced with a minor valve palsy, followed by a fall, dislocating shoulder, which required 24-hour care due to the patient's lack of mobility and this was followed by a general deterioration through strokes and final paralysis.

The care required at nursing home did not lend itself to medicare participation; as a matter of fact, in November 1971 an accrual of nursing home care was met with retroactive denial. These expenditures are the patient's participation over and above Medicare, parts A and B, plus an augmented Blue Cross policy. I am attempting to gather the information on Medicare and Blue Cross participation during the same period which will be forwarded.

The receipts and accompanying documents, as well as the disbursement of checks, have been verified by our office and are subject to review if necessary. We feel this fully documents the high cost of medical services which most crtainly represents a case for revision.

It might be added that this client had worked the greater part of her life, had managed to save much of this money in small amounts that she had paid her own way and that if this decline had continued over a few short months at this rate she would most certainly would have had to rely on welfare assistance. There is a growing concern on the part of many older people that not enough money can be saved to take care of the high cost of medical services even with some insurance protection. Sincerely hope this information is beneficial to you and the committee.

Respectfully submitted,

JESSE J. FULLER,
Executive Director.

[Enclosure]

Date	Check No.	Name	Amount
Aug. 23, 1971	680	Dr. Gipson	$20.00
Do	681	Dr. Pasach	27.00
Sept. 27, 1971	686	Dr. Weinstein	15.00
Nov. 22, 1971	695	Medicenter	1,103.90
Dec. 20, 1971	716	Ambulances, Inc	31.00
Jan. 12, 1972	724	Medicenter	1,481.26
Do	725	University Park	405.00
Feb. 10, 1972	732	Ambulances, Inc	5.20
Feb. 18, 1972	735	Golden Shores	119.00
May 19, 1972	743	Dr. Cordrey	128.00
June 12, 1972	751	Dr. Rodgers	475.50
Do	752	Golden Shores	1,762.79
June 13, 1972	753	University Park	101.60
June 15, 1972	754	St. Joseph Hospital	48.00
Sept. 7, 1972	760	Golden Shores	1,735.81
Do	761	Dr. McConnell	50.00
Do	763	Patterson Coleman Lab	4.00
Do	765	Medicenter	30.50
Do	767	Dr. Rodgers	15.00
Sept. 26, 1972	768	Dr. Cordrey	233.00
Nov. 14, 1972	777	Golden Shores	1,128.97
Nov. 16, 1972	778	Manhattan Home	266.25
Feb. 26, 1973	783	Manhattan Home	1,693.82
Mar. 5, 1973	784	Golden Shores	377.64
		Total	11,258.24
May 18, 1973	791	Manhattan Home	798.95
		Total	12,057.19

○